MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

10147

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months + 16 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium + Hospital

How long in hospital or institution? 3 months + 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Col. County:

City or town: Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3804 Windon Pl. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Hcock, Mr. Frederick W.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Ethel L. Hcock

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1880

8. AGE:

Years	Months	Days	If less than one day
67	9	4	....hrs. ....min.

9. Birthplace: London, England (Town, county, and state)

10. Usual occupation: Architect

11. Industry or business: State Dept. U.S.H.

FATHER

12. Name: George Thomas Hcock

13. Birthplace: England

MOTHER

14. Maiden name: Harriet Woodfield

15. Birthplace: England

16. Informant: Washington San. + Hosp. Records

Address: Takoma Park, Maryland

17. Removal ~~Burial~~ (Burial, cremation, or removal. Which?) Date thereof: 11 29 47 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D C

18. Funeral director: The S H Harris Co.

Address: 2901-14 ~~G~~ N.W.

19. Nov 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 1947, at 7:12 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19.. to Nov. 29 1947

and that I last saw h... alive on Nov 28 1947

Immediate cause of death	DURATION
Diabetic Gangrene	2 wks
Due to: Arteriosclerosis	? years
Due to: Diabetes Mellitus	? years
Other conditions: Pericarditis	3 mos

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Confirm above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert A Stare M.D. M. D. or other

Address: Takoma Park, Md. Date signed: 11/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10148

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: PG

City or town: College Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: c/o H. M. Marlow

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: ADAMS, Walter Thomas

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 12, 1893

8. AGE:

Years	Months	Days	If less than one day
53	11	10	hrs. min.

9. Birthplace: Md.

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: ADAMS, John T. dec.

13. Birthplace: Md.

MOTHER

14. Maiden name: WALKER, Mary Jane dec.

15. Birthplace: Md.

16. Informant: sister: Mrs. Annie Lee

Address: College Park, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-26-47 (month) (day) (year)

Cemetery or crematory: Good Hope

Location: Colesville, Md.

18. Funeral director: SNOWDEN Funeral Home R. L. Snowden

Address: Rockville, Md.

19. 11-24 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 19 47 at 9:56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 19 47 to November 22 19 47 and that I last saw h. im alive on 22 November 19 47

Immediate cause of death	DURATION
Congestive heart failure	36
Due to: Hypertensive Heart Disease	5 mos. yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: , Date of op.

Autopsy results: Confirm above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. E. Billman 11/25/47

D. E. BILLMAN, Lt. JG MC USN

M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-24-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
NOV 26 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 1a

10149

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 3rd St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: ALGATE, Roy Tarry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1881

8. AGE: Years	Months	Days	If less than one day
66	7	24	hrs. min.

9. Birthplace: N.Y. (Town, county, and state)

10. Usual occupation: Retired Govt. Employee

11. Industry or business

FATHER — 12. Name: ALGATE, John B. dec.

13. Birthplace: Eng.

MOTHER — 14. Maiden name: DAMON, Harriot Ann dec.

15. Birthplace: N.Y.

16. Informant: brother: Mr. Stanley W. Algate

Address: 509 3rd St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: burial (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 11-25-47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25, 1947, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Nov. 1947 to 25 Nov. 1947

and that I last saw him alive on 25 Nov. 1947

	DURATION
Immediate cause of death: Coronary thrombosis	2 wk.
Due to: Pulmonary infarction	1 wk.
Due to: Venous thrombosis, femoral	1 wk.
Due to:	
Other conditions: arteriosclerosis nephrosclerosis & lithiasis (Include pregnancy within 3 months of death) Hypertension Sys. +	

Major findings of operations: Date of op.

Autopsy results: Coronary thrombosis & pulm. infarct

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. E. Wetzel F. E. WETZEL, Lt. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

10151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 100 Baltimore Ave.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New York County:

City or town: Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1432 Park Pl.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Anna Annenberg

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 18, 1901

8. AGE: Years: 46 Months: Days: If less than one day: hrs. min.

9. Birthplace: New York N.Y. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Benjamin Annenberg

13. Birthplace: Lithuania

MOTHER — 14. Maiden name: Florie Weinstine

15. Birthplace: Austria

16. Informant: Mrs Sarah Preas

Address: 4705 Hardman Rd College

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26, 1947 (month) (day) (year)

Cemetery or crematory: Hebrew Friendship Cemetery

Location: Baltimore, Md.

18. Funeral director: Frank Geier Sons Co

Address: Washington D.C.

19. Nov. 25 1947 (Date rec'd by registrar) J. Holmdell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Nov. 1947 at 7 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Oct. 1947 to 25 Nov. 1947 and that I last saw her alive on 24 Nov. 1947

Immediate cause of death	DURATION
Auricular Fibrillation (Cardiac Failure)	6 days.
Due to: Chronic Myocarditis	4-5 years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work?

23. SIGNATURE: H B Cullen M.D.

M. D. or other

Address: 112 Willow Ave. Takoma Park, Md. Date signed: 11-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10152

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Street address where death occurred:
703 Richmond Ave.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 703 Richmond Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: George B. Bailey

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Eva
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 18th. 1903

8. AGE: Years	Months	Days	If less than one day
44	3	11	hrs. min.

9. Birthplace: St. Marys, Md.
(Town, county, and state)
10. Usual occupation: Clerk - U. S. Goverment
11. Industry or business

FATHER
12. Name: William A. Bailey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Combs
15. Birthplace: Maryland

16. Informant: Mrs. Eva Bailey
Address: 703 Richmond Ave. Silver Spring

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 12-2-1947
(month) (day) (year)
Cemetery or: Cedar Hill
Location: Suitland, Pr. Georges Co. Md.

18. Funeral director: Mane & Cumpston
Address: Silver Spring. Md.

19. Nov. 29 1947 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 29 1947 at 4:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. Med. Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	Being unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Boschart M. D.
Dep. Med. Exam. M. D. or other
Address: Silver Spring Md. Date signed 11-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

125 B   10150   Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred: U. S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ______ County: ______

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1308 Fairmont Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war ______

3.(a) FULL NAME BALL, Marie Anastosia

3.(b) Social Security Number ______

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: James E. Ball

6.(c) If alive, give age ______ years

7. Birth date of deceased (mo., day, yr.): April 29, 1911

8. AGE:	Years	Months	Days	If less than one day
	36	6	6	______ hrs. ______ min.

9. Birthplace: Texas
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business ______

FATHER
12. Name: HOSEK, Tom
13. Birthplace: Czechoslavahia

MOTHER
14. Maiden name: ANASTOSIA, ?
15. Birthplace: Cyechoslavahia

16. Informant: husband: James E. Ball, CRM USN
Address: 1308 Fairmont St., N.W. Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Hollywood

Location: Houston, Texas

18. Funeral director: Warner Pumphrey, 8434 Georgia Ave., W.E.P.
Address: Silver Springs, Md.

19. 11-6 1947 Mary C. Patterson — Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1947 at 4:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9, 1947, to November 5 1947 and that I last saw her alive on 5 November 1947

		DURATION
Immediate cause of death	Terminal Uremia c Acidosis	3 days
Due to	Acute Hepatitis c Cholemia	2 months
Due to	Unknown	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations ______ Date of op. ______

Autopsy results ______

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ______ Date of ______

Where did injury occur? ______ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ______

Means of injury ______ Injured at work? ______

23. SIGNATURE: C. C. Matowitz M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-6-47

W.S. AH5 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 10153

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution~~ or street address where death occurred:
Gray Rd. near Kemp Mill Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Grsv Rd. near Kemp Mill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: SILAS EUGENE BEAN

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Valma Cornwell

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 14th. 1888

8. AGE: Years	Months	Days	If less than one day
69	2	26	____ hrs. ____ min.

9. Birthplace: Colesville, Maryland
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: John Asbury Bean
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Ellen Barnes
15. Birthplace: D. C.

16. Informant: Silas E. Bean, Jr.
Address: Kemp Mill Rd. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/13/1947 (month) (day) (year)

Cemetery or crematory: St. Johns

Location: Forset Glen, Montg. Co. Md.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Nov. 17 1947 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 10 1947, at 11:35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1944, to Nov. 10 1947 and that I last saw h. l. m. alive on Nov. 8 1947

	DURATION
Immediate cause of death: Uremic Coma	2+ days
Due to: Arteriosclerotic Kidney disease	2+ yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.: ____

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Silver Spring, Md. Date signed: 11/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82 10155

CERTIFICATE OF DEATH

Reg. Dist. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Ednor (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Ednor Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Florence Miller Bond

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	Married

B (b) Name of husband or wife: Charles E.

6(c) If alive, give age: years

7. Birth date of decease (mo., day, yr.): Nov. 23rd. 1873

8. AGE: Years	Months	Days	If less than one day
74	0	3	hrs. min.

9. Birthplace: Sandy Spring, Md. (Town, county, and state)

10. Usual occupation: Retired Housewife

11. Industry or business

FATHER — 12. Name: Robert B. Stabler

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anna B. Taylor

15. Birthplace: Virginia

16. Informant: Mr. Charles E. Bond

Address: Ednor, Montg. C. Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 11/28/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Pr. Geo's Co. Md.

18. Funeral director: Warner E. Pumphrey Inc.

Address: Silver Spring, Md.

19. Nov. 27, 1947 (Date rec'd by registrar) Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-26 1947, at 6:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-5- 1942, to 11-26 1947, and that I last saw h e alive on 11-24 1947.

	DURATION
Immediate cause of death: Pneumonia, Hypostatic	1 day
Due to: Pharyngeal Abscess	2 days
Due to:	
Other conditions: Senile Myelitis + Tic Douloureux (Include pregnancy within 3 months of death)	7 to 9 yrs
Major findings: Tic Douloureux	
Of operations:	
Of autopsy:	

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. H. Lumm M.D. (M. D. or other)

Address: 900 Georgia Ave. Date signed: 11-27-47.

10154

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a

CERTIFICATE OF DEATH

Reg. Dist. No. 3 14

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
9412 St. Andrews Way

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9412 St. Andrews Way
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Ella Marie Boote

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Ward E. Boote

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1898

8. AGE: Years	Months	Days	If less than one day
49	9	7	....hrs. ....min.

9. Birthplace Laceyville, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Judson L. Carter
13. Birthplace Pa.

MOTHER
14. Maiden name Vena Quinby
15. Birthplace Pa.

16. Informant Ward E. Boote

Address 9412 St. Andrews Way

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland, Md.

18. Funeral director Wayne E. Pumphrey

Address 8434 Ga. Ave., Silver Spring, Md.

19. Nov. 14 1947 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1947, at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 1947, to Nov. 11 1947

and that I last saw h... alive on Nov. 11 1947

Immediate cause of death	DURATION
Carcinoma of ovary	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis K. Alpert M.D
M. D. or other

Address 1801 K St. N.W. Date signed Nov. 14 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Mr. Louis Kaehn
1801 - K St
Suite 611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e 10156

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day : 11 hrs. 3/4

Hospital, institution, or street address where death occurred:

WASHINGTON SANITARIUM & HOSPITAL

How long in hospital or institution? 1 day : 11 3/4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: Montgomery

City or town: Takoma Pk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9305 Long Branch Pkwy.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

~~Baby Girl~~ BOWER, Annabel Gertrude

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	—

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1947

8. AGE: Years | Months | Days | If less than one day: 36 hrs. min.

9. Birthplace: TAKOMA PARK, MARYLAND (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: RALPH EDMUND BOWER

13. Birthplace: PHILADELPHIA, PA.

MOTHER

14. Maiden name: MARION BROTHWELL

15. Birthplace: NEW YORK CITY

16. Informant: WASHINGTON SANITARIUM Hosp. Records

Address: TAKOMA Park, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Nov. 23-1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Wash. D. C.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md

19. Nov 22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 21 1947 at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1947 to Nov. 21 1947 and that I last saw her alive on Nov. 21 1947

	DURATION
Immediate cause of death: Anoxia	36 hrs.
Due to: Anomalous fusion of Pulmonary artery + aorta. —	Embryonic
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Anomalous fusion of pulm. art. + aorta

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D.

M. D. or other

Address: Silver Spring, Md. Date signed: 11/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160 c

10157

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital Inc

How long in hospital or institution? 15 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Olney

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Frederick Bowie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9, 1947

8. AGE:

Years	Months	Days	If less than one day
			15 hrs. 5 min.

9. Birthplace Olney, Montgomery County, Md.

(Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER

12. Name Frederick Douglas Johnson

13. Birthplace Maryland

MOTHER

14. Maiden name Alice Virginia Bowie

15. Birthplace Olney, Maryland

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 10-1947 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Montgomery Co Md

18. Funeral director Roy W Barker

Address Laytonsville, Md.

19. Nov 10 1947 (Date rec'd by registrar) Gertrude B Zander Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 19 47, at 5:56 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9, 1947 19, to November 9 19 47

and that I last saw him alive on November 9 19 47

Immediate cause of death	DURATION
Atelectasis	15 hrs
Due to Prolonged labor	48 hrs
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Sandy Spring, Md Date signed 11/10/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 e α

10158

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 2 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Crockett

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route #1

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BRALLEY, Thomas Oakland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 7, 1925

8. AGE:

Years	Months	Days	If less than one day
22	4	6	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business

FATHER

12. Name: Bralley, Grover dec.

13. Birthplace: Va.

MOTHER

14. Maiden name: HURT, Edith dec.

15. Birthplace: Va.

16. Informant: sister: Mrs. Helen Haga

Address: Crockett, Virginia, Rt. #1

17. removal (Burial, cremation, or removal. Which?) Date thereof: 11-13-47 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: W. W. CHAMBERS W. J. T.

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 11-13 19 47 Mary C. Patterson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 November 19 47 at 5 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 11 19 47 to 13 Nov 19 47

and that I last saw h... im alive on 13 November 19 47

	DURATION
Immediate cause of death: Cerebral Metastases. Adenocarcinoma.	weeks
Due to: Carcinomatosis.	
Due to: Adeno Carcinoma of Desc. Colon.	Mos.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinomatosis. Abdominal. Date of op. 10/30/47.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. A. Murphy. H. A. MURPHY, Cdr. MC USN M.D., or other

Address: USNH Bethesda, Md. Date signed: 11-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10159

Reg. Dist. No. 213

MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: ROCKVILLE
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Chestnut Lodge Sanitarium

Stay in hospital or inst. (yrs., or mos., or days): 27 days

Stay in this community (yrs., or mos., or days): 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Washington

City or town: HAGERSTOWN Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 629 OAK HILL
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: HARRY E. BRANDT

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife: MARY E. BRANDT

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): May 25, 1863

8. AGE: Years	Months	Days	If less than one day
84	5	10	hrs. min.

9. Birthplace: MECHANICSBURG, PENNA.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: FURNITURE MANUFACTURER

FATHER
12. Name: Edward S. BRANDT
13. Birthplace: Penna.

MOTHER
14. Maiden name: Anna Lee Garland
15. Birthplace: Mechanicsburg, Pa

16. Informant: MARY E. BRANDT
Address: 629 OAK HILL, HAGERSTOWN, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/7/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md

18. Funeral director: A R Coffman

Address: Hagerstown Md.

19. 11-4-1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV. 4, 1947, at 1:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8, 1947 to Nov. 4, 1947, and that I last saw him alive on Nov. 4, 1947.

	DURATION
Immediate cause of death: ACUTE HEART FAILURE	3 hrs.
Due to: HYPERTENSIVE CARDIO-VASCULAR DISEASE	25 yrs.
Due to:	
Other conditions: Enlarged Prostate; Bilateral Deafness	?

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph W. Cosa, M.D.
M. D. or other

Address: Chestnut Lodge Sanitarium, Rockville, Md. Date signed 11/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

926

10160

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1807 4th Street, Northwest

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME

BROWN, William Edward

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	unknown

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11 February 1892

8. AGE: Years	Months	Days	If less than one day
55	8	27	hrs. min.

9. Birthplace: Petersville, Maryland (Town, county, and state)

10. Usual occupation: Chaufeur

11. Industry or business

FATHER

12. Name: unknown

13. Birthplace: unknown

MOTHER

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Friend: Mr. John Brown

Address: 1807 4th St., NW, Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-13-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Frazier Funeral Home E. Jones

Address: 389 Rhode Island Ave., NW, Wash., D.C.

19. 11-10 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 November 19 47 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-8- 19 47 to 11-8- 19 47 and that I last saw h. i.m. alive on 11-8- 19 47

Immediate cause of death	DURATION
Rheumatic Heart Disease	
with congestive failure	?
Due to:	
Due to:	
Other conditions: Aortic and mitral stenosis	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. E. Watters L. E. WATTERS, LTJG MC USNR M. D. or other

Address: USNH, Bethesda, Md. Date signed: 11-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10161

Reg. Diat. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two years

Hospital, Institution, or street address where death occurred: 345 Boyd Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 345 Boyd Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Isler Bush

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Bessie Elizabeth Bush 6.(c) If alive, give age: 64 years

7. Birth data of deceased (mo., day, yr.): April 3, 1882

8. AGE:

Years	Months	Days	If less than one day
65	7	27	...hrs. ...min.

9. Birthplace: Reading, Pa. (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business

FATHER

12. Name: William Bush

13. Birthplace: Reading, Pa.

MOTHER

14. Maiden name: Hope Eppenhiner

15. Birthplace: Reading, Pa.

16. Informant: Mr. Joseph Smith

Address: 9210 Midwood Rd., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 2, 1947 (month) (day) (year)

Cemetery or crematory: Grace Episcopal Church Cemetery

Location: Woodside, Silver Spring, Md.

18. Funeral director: Arthur E. Bailey

Address: 257 Carroll Ave. N.W. Takoma Park, D.C.

19. Dec 1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30, 1947 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above etated; that I attended daceaeed from April 18, 1947 to Nov. 29, 1947 and that I last saw h..im alive on November 29, 1947

	DURATION
Immediate cause of death: Coronary Occlusion	2 days
Due to: Arteriosclerotic heart disease with recurring attacks of Angina Pectoris	5 yrs.?
Other conditions: Deafness	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury Injured at work?

23. SIGNATURE: Wallace N. Mook M.D.

805 Carroll Avenue, M. D. or other

Address: Takoma Park 12 Md. Date signed: 11-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160c

10162

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 556 14th St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

CARROLL, Baby Boy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1947

8. AGE: Years | Months | Days | If less than one day: 2 hrs. 20 min.

9. Birthplace: Md.
(Town, county, and atate)

10. Usual occupation:

11. Indusiry or business

MOTHER FATHER

12. Name: CARROLL, Richard

13. Birthplace

MOTHER

14. Maiden name: HAAS, Ann Carolyn

15. Birthplace: N.C.

16. Informant: Mother: Mrs. Ann C. Carroll

Address: 556 14th St., S.E., Wash., D.C.

17. turned over to: Date thereof: 11-25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Pathological Dept.

Location: Naval Medical School, Bethesda, Md.

18. US Naval Medical School,

Address: National Naval Medical Center, Bethesda, Md.

19. 11-25- 1947 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 1947, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1947, to Nov. 24 1947 and that I last saw him alive on Nov. 24 1947

	DURATION
Immediate cause of death: Premature birth - immaturity 5½ month Gestation	2½ hrs.
Due to: Placenta previa.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul Peterson PAUL PETERSON, Capt. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

94a 10163

CERTIFICATE OF DEATH

216

Reg. Dist. No.

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years, 1 mo., 9 days
Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? 5 yrs., 1 mon., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2126 Conn.Avenue, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3. (a) FULL NAME: CLARK, Frank Hodges, Rear Admiral USN Ret.Inact.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Mrs. Nina Clark
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 18, 1871

8. AGE: Years	Months	Days	If less than one day
75	10	18	hrs. min.

9. Birthplace: Mass. (Town, county, and state)
10. Usual occupation: Retired Navy
11. Industry or business:

FATHER
12. Name: CLARK, Frank H. dec.
13. Birthplace: Mass.

MOTHER
14. Maiden name: PHILBRICK, Mary dec.
15. Birthplace: Mass.

16. Informant: Mrs. Nina Clark
Address: 2126 Conn.Avenue, N.W., Wash., D.C.

17. burial (Burial, cremation, or removal: Which?) Date thereof 11-10-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Joseph Gawler Joseph Gawler's Son
Address: 1750 Penn.,Avenue, N.W., Wash.,D.C.

19. 11-7 (Date rec'd by registrar) 19 47 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 19 47, at 9:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Sept. 19 42 to 6 November 19 47 and that I last saw him alive on 6 November 19 47

Immediate cause of death	DURATION
Coronary Thrombosis with Myocardial Infarction	36 hours
Due to: Arteriosclerosis Generalized	6 years
Due to: Arterial Hypertension	8 years
Other conditions: Cerebral Hemorrhage (Include pregnancy within 3 months of death)	5 years

Major findings of operations:
Date of op.:
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: T. B. JARRETT, Cdr. MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed 11-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WS AUG 99-465-15SM

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10164

CERTIFICATE OF DEATH

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Seneca
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, institution, or street address where death occurred: None
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Seneca
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME Mary Agnes Connell

3.(b) Social Security Number None

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1865

8. AGE: Years: 82 | Months: 9 | Days: 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Tenleytown, Washington, D.C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: William G. Connell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ann Counselman
15. Birthplace: Washington, D.C.

16. Informant: Sidney Connell
Address: Seneca, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 21, 1947 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: Wm. Rabbon Funeral Home
Address: Bethesda, Md.

19. 11/21 1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19 1947, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27 1947, to Nov. 19 1947
and that I last saw her alive on Nov. 18 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 20 hrs.

Due to: .....

Due to: .....

Other conditions: senility & Cardio-nephritis

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: William E. Miller M.D.
M. D. or other
Address: Gaithersburg Md. Date signed: 11-20-47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10165

462

Reg. Dist. No. 223.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of deaih?
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 10 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg.
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1703 Dennis Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: MRS. GRACE V. CROTTS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Corbin Central
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22nd. 1896

8. AGE: Years	Months	Days	If less than one day
51	4	5	hrs. min.

9. Birthplace: Lexington, N. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Willard Sink
13. Birthplace: Tennessee

MOTHER
14. Maiden name: Irene McKinley
15. Birthplace: North Carolina

16. Informant: Mr. Cody F. Crotts (son)
Address: 1111 Mt. Olivet St. N.E. Wash.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-1-1947 (month) (day) (year)
Cemetery or crematory: Colesville Methodist Church
Location: Colesville, Montg. Co. Md.
18. Funeral director: Deane & Pumphrey
Address: Silver Spring, Md.

19. Nov. 29 1947 (Date rec'd by registrar) F. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 1947 at 2.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1943 to Nov. 27 1947 and that I last saw h. alive on Nov. 27 1947

Immediate cause of death	DURATION
Cachexia	3 mo.
Due to Generalized carcinomatosis	6+ mo.
Due to Primary adenocarcinoma of transverse colon	4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Right half of colon resected for adenocarcinoma Date of op. March 1944
Autopsy results: Generalized carcinomatosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: Silver Spring, Md. Date signed: 11/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

10166

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery County
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, institution, or street address where death occurred:
Cummings Lane,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cummings Lane,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CUMMINGS, Zelpha Lawyer

3.(b) Social Security Number: 214-12-7376

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Andrew J. Cummings
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 28, 1882

8. AGE: Years	Months	Days	If less than one day
65	3	5	..... hrs. ..... min.

9. Birthplace: Milroy, Pa. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Contener
13. Birthplace: Pa.

MOTHER
14. Maiden name: ? Ross
15. Birthplace: Pa.

16. Informant: Andrew J. Cummings, Jr.
Address: 6625 Hillindale, Ch. Ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/6/47 (month) (day) (year)
Cemetery or crematory: St. Johns Cemetery
Location: Forest Glen, Maryland

18. Funeral director: Wm Reuben Humphrey
Address: 7557 Wis. Ave. Bethesda, Maryland

19. 11/14/47 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 19 47 at 9:32 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 47, to Nov. 3 19 47 and that I last saw h... alive on Nov. 3 19 47

Immediate cause of death: Ulcer. Carcinomatosis breast, lungs, cerv. glands — DURATION: 2 yrs

Due to:

Due to:

Other conditions: Acute respiratory & cardiac failure — DURATION: 8 hrs.
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H E Finnstein M. D. or other
Address: 3311-16. N. H. Date signed: 11/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10167

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 days 14 hours 45 Min.

Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 71 days 14 hours 45 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3618 Prospect St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mr. James J. Davis

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: Jeannette R. Davis

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 27 1873

8. AGE: Years	Months	Days	If less than one day
74	—	26	..... hrs. ..... min.

9. Birthplace: South Wales
(Town, county, and state)

10. Usual occupation: Fraternity Organizer

11. Industry or business: U.S. Gov't.

FATHER
12. Name: David J. Davis
13. Birthplace: South Wales

MOTHER
14. Maiden name: Esther Ford Nichols
15. Birthplace: South Wales

16. Informant: Self

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: November 23 1947 (month) (day) (year)

Cemetery or crematory:

Location: Pittsburgh, Pennsylvania

18. Funeral director: The S. D. Hines Co.

Address: 2901 14th Street N.W. Washington D.C.

19. Nov. 25 1947 (Date rec'd by registrar) Josephine Schaaff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 1947 at 12:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11 1947, to Nov. 22 1947 and that I last saw him alive on Nov. 21 1947

Immediate cause of death	DURATION
Congestive Cardiac Failure	Terminal
Due to: Hypertension	4 years
Due to: Arteriosclerosis	4 years
Other conditions: Chronic Nephritis	4 years

(Include pregnancy within 3 months of death)

Major findings of operations: X

Date of op.:

Autopsy results: X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert A. Hare M.D. (M.D. or other)

Address: Takoma Park Md. Date signed: 11/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108 10168

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 11-21-47 - 10:45Am

Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd. - Bethesda Md.

How long in hospital or institution? Since 11-21-47 10:45A.m.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Washington County D. C.

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2525 Pennsylvania Ave., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME Mr Stanley Deasy

3. (b) Social Security Number yes but unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m.	W	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 15, 1896

8. AGE: Years	Months	Days	If less than one day
51 51	10	7	..... hrs. ..... min.

9. Birthplace Cincinnati Ohio
(Town, county, and state)

10. Usual occupation manager ?

11. Industry or business Restaurant Business.

FATHER
12. Name Timothy Deasy
13. Birthplace Cincinnati Ohio

MOTHER
14. Maiden name Ann McHugh
15. Birthplace Kentucky

16. Informant Mrs. Florence Aldemeyer
Address Cincinnati 2, Ohio

17. Removal-Transit (Burial, cremation, or removal. Which?) Date thereof Nov. 23, 1947 (month) (day) (year)

Cemetery or crematory Fuldner Funeral Home

Location Cincinnati, Ohio

18. Funeral director Wm. Reuben Pumphrey

Address Bethesda 14, Maryland

19. 11/23/47 (Date rec'd by registrar) 19..... Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-47 19..... at 8:30 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 19 1947 to Nov 22 1947 and that I last saw h.im alive on Nov 21 1947

Immediate cause of death	DURATION
Lobar Pneumonia	1 wk
Due to	
Due to	
Other conditions Rheumatic Heart Disease	30 yrs

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results Lobar Pneumonia, Rheumatic Heart Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Robert Perkins Jr. M.D.
M. D., or other

Address 1466 - Rhode Island Ave. N.W. Washington DC Date signed 11/23/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

10169

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital or Institution~~ or street address where death occurred:
619 Gist Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 619 Gist Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MRS. BELLE GOULDING DICKEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Charles A.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 5th. 1869

8. AGE: Years	Months	Days	If less than one day
78	9	19	..... hrs. ..... min.

9. Birthplace: Minnesota (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: John W. Goulding
13. Birthplace: Minn.
MOTHER 14. Maiden name: Abigail Rines
15. Birthplace: Minn.
16. Informant: Mrs. Dorothy D. Boss
Address: 619 Gist Ave. Silver Spring.
17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof 11/26/1947 (month) (day) (year)
Cemetery or crematory: Oak Knolls
Location: Princeton, Middlesex Co. Minn
18. Funeral director: Warner Dunphrey
Address: 8434 Ga. Ave. Silver Spring, Md.
19. Nov. 25 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 1947, at 2 25 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-4 1947 to 11-24 1947 and that I last saw h.e.r. alive on 11-24 1947

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Hypertension	
Due to: Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dean A Harding MD M. D. or other
Address: 113 Carroll St NW Wash DC Date signed 11-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10170

CERTIFICATE OF DEATH

Reg. Diat. No. 714

1. PLACE OF DEATH:

County MONTGOMERY

City or town SILVER SPRING.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution, or~~ street address where death occurred:
1704 NOYES LANE

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town SILVER SPRING.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1704 NOYES LANE
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Babette Dickinson

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife FREDERICK M.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB-4TH 1878.

8. AGE: Years	Months	Days	If less than one day
69	9	10	..... hrs. ..... min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JOHN WIRTH.
13. Birthplace GERMANY

MOTHER
14. Maiden name UNKNOWN.
15. Birthplace UNKNOWN.

16. Informant MR HARRY J. DICKINSON (SON)

Address 8814 - 1st AVE SILVER SPRING. MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof NOV 17 1947 (month) (day) (year)

Cemetery or crematory FORT LINCOLN CEMETERY.

Location BLADENSBURG RD. PRINCE GEORGES CO MD

18. Funeral director Warren E. Pumphrey

Address SILVER SPRING. MD

19. NOV. 17 1947 (Date rec'd by registrar) Josephine Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 14 1947, at 4:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def. med. Exam case, 19 ..... to ..... 19 .....
and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary occlusion	Sev'l days
Due to	.....
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Bouchart M.D.
Def. med. Exam.
M. D. or other

Address Gaithersburg Md. Date signed 11-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10171

170C

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MONTGOMERY

City or town FAIRLAND (R.F.D. 2, SILVER SPRING)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war WORLD WAR II

3.(a) FULL NAME William Calvin Dodson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1923

8. AGE: Years	Months	Days	If less than one day
24	9	15	..... hrs. ..... min.

9. Birthplace Silver Spring, Mont. Co. Md.
(Town, county, and state)

10. Usual occupation Plumber

11. Industry or business

FATHER — 12. Name Hezekiah Dodson

13. Birthplace Culpepper, Va.

MOTHER — 14. Maiden name Flossie Watkins

15. Birthplace Brownsville, Md.

16. Informant Gordon J. Dodson

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1947 (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director Arthur Walters

Address 254 Carroll St. N.W., Takoma Park 12, D.C.

19. 11/3 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1947 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept med Exam 19.. to ..19..

and that I last saw h..... alive on ..19..

Immediate cause of death	DURATION
Fracture of skull	3½ hrs.
Due to auto accident (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-3-47

Where did injury occur? Near Wheaton (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury auto accident Injured at work? No

23. SIGNATURE Frank J. Bosenberg M.D. M. D. or other

Address Gaithersburg Md Date signed 11-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Diat. No. 10182

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Millboro Springs
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWII

3. (a) FULL NAME
DRISCOLL, Marion Raymond

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 2, 1898

8. AGE: Years	Months	Days	If less than one day
49	4	14	... hrs. ... min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER
12. Name: DRISCOLL, James dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: GILLOCK, Bessie dec.
15. Birthplace: Va.

16. Informant: sister: Mrs. W. B. Wood
Address: Millboro Springs, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11-18-47 (month) (day) (year)

Cemetery or crematory: Clifton Forge Cemetery

Location: Clifton Forge, Va.

18. Funeral director: William Reuben Pumphrey J. P.

Address: 7557 Wis. Ave., Bethesda, Md.

19. 11-16- 1947 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 November 1947 at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 November 1947 to 16 November 1947 and that I last saw him alive on 16 November 1947

Immediate cause of death	DURATION
Coronary disfunction	7 days
Due to: Coronary sclerosis	—
Due to: Generalized arteriosclerosis	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

P. E. Billman

23. SIGNATURE: D. E. BILLMAN, Lt JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

462 10173

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months
Hospital, institution, or street address where death occurred:
Wilson Lane
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Wilson Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Dr. William S. Dysinger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Laura M. Dysinger
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): October 1st, 1862

8. AGE: Years	Months	Days	If less than one day
85 85	1	12	— hrs. — min.

9. Birthplace: Mifflintown, Pa.
(Town, county, and state)
10. Usual occupation: Minister (Retired)
11. Industry or business: Luthern Church

FATHER
12. Name: Jacob Dysinger
13. Birthplace: Penn.

MOTHER
14. Maiden name: Mary Patterson
15. Birthplace: Penn.

16. Informant: Mrs. Laura M. Dysinger (wife)
Address: Wilson La., Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 15, 1947 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: Wm Reuben Thompsey
Address: Bethesda, Maryland

19. 11/15 1947 Wm E Lobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13th, 1947, at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEBRUARY 1947, to NOVEMBER 12 1947
and that I last saw him alive on NOVEMBER 12 1947

Immediate cause of death	DURATION
ACUTE RESPIRATORY FAILURE	
Due to CARCINOMA OF THE DESCENDING COLON WITH EXTENSIVE METASTASES	ONE YEAR
Due to	
Other conditions ANEMIA, SENILE HYPERTENSION WITH CEREBRAL ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Major findings of operations: COLOSTOMY PERFORMED AUG. 1947
LAB. REPORT: ADENOCARCINOMA Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank S. Hovath, M.D. M. D. or other
Address: 1801 Eye St., N.W. Wash D.C. Date signed: 11-14-47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

193 10174

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Maryland. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden death.

Hospital, institution, or street address where death occurred: Cedar Pkwy. and Oliver St.

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Berwyn (If outside city or town limits, write RURAL and give nearest town)

Street No. 9505 Baltimore Blvd. (If rural, give LOCATION)

2.(a) If veteran, name war: World War II; 347-11111

3.(a) FULL NAME: Malone Sibley Eddleman

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1912

8. AGE: Years: 35 Months: 1 Days: 28 If less than one day: ... hrs. ... min.

9. Birthplace: Memphis, Tenn. (Town, county, and state)

10. Usual occupation: Crane Mechanic

11. Industry or business: Bles Construction Co.

FATHER 12. Name: Wallace R. Eddleman

13. Birthplace: Georgia

MOTHER 14. Maiden name: Myrtle Vincent

15. Birthplace: Indiana

16. Informant: Wallace R. Eddleman

Address: 9505 Baltimore Blvd., Berwyn, Md.

17. (Burial, Cremation, or Removal. Which?) Burial-transit Date thereof: Nov. 8, 1947 (month) (day) (year)

Cemetery or crematory: Memphis, Tenn.

Location: Memphis, Tenn.

18. Funeral director: Wm. Loudon Pumphrey

Address: Bethesda, Maryland.

19. (Date rec'd by registrar) 11/7 1947 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7, 1947 at 7:30A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
DEP. MED. EXAM. CASE	
Due to: Electrocution	Died Suddenly
Accidental	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Nov. 7, 1947

Where did injury occur? Bethesda (City or town) Montgomery (County) Md. (State)

Injured at home, farm, industry, public place (where?): Public Place

Means of injury: Electrocution Injured at work? Yes

23. SIGNATURE: Frank J. Broschart M.D.
Deputy Medical Examiner (M.D. or other)

Address: Gaithersburg, Md. Date signed: Nov. 7, '47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10175

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Gaithersburg, Montgomery
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Twenty years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town SHADY GROVE ROAD
(If outside city or town limits, write RURAL and give nearest town)
Street No. GAITHERSBURG.
(If rural, give LOCATION)
2.(a) If veteran, name war NONE

3. (a) FULL NAME MABLE, LLOYD ELDER

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife JAMES LEO ELDER
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 29. 1896

8. AGE: Years	Months	Days	If less than one day
52	1	26	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation FARMING
11. Industry or business FARM

FATHER
12. Name OLIVER BRIGGS
13. Birthplace MARYLAND

MOTHER
14. Maiden name ELLA PENN. BRIGGS
15. Birthplace MARYLAND

16. Informant ELLA E. HAWKINS
Address GAITHERSBURG MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof NOV. 27. 1947 (month) (day) (year)
Cemetery or crematory ST. MARYS
Location ROCKVILLE
18. Funeral director ROY W. BARBER
Address LAYTONSVILLE

19. 11-26 1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1947, at 6 o'c P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19..., to Nov. 24 1947.
and that I last saw h[illegible] alive on Nov. 24 1947

Immediate cause of death	DURATION
Cerebral arteriosclerosis & hypertension	5 years
Due to	
Due to	
Other conditions: Cerebral Hemorrhage; Right Hemiplegia	11 months.

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm P. Smithers, M.D. M. D. or other
Address Rockville, Md. Date signed 11/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1572 10176

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Monty Co
City or town: Gaithersburg. md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Monty
City or town: Gaithersburg.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robut M. Fairbanks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): aug 7th - 1947

8. AGE: Years	Months	Days	If less than one day
	3	4	hrs. min.

9. Birthplace: Monty Co Md.
(Town, county, and state)
10. Usual occupation: a
11. Industry or business: a

FATHER
12. Name: unknown
13. Birthplace: "

MOTHER
14. Maiden name: Elizabeth Fairbanks
15. Birthplace: Monty Co md

16. Informant: Margaret Stone - Social Leader
Address: Monty Co: Rockville md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/12/47 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg md
18. Funeral director: Joseph C Gaither
Address: Gaithersburg Md.
19. Nov. 12 1947 (Date rec'd by registrar) Arnold G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 11 19 47, at 3:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec med Exam 19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Congenital heart dease	Dec'd died in crib
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Bosshart M.D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg md Date signed 11-11-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50K

10177

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital 8600 Old Georgetown Rd Bethesda Md

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 4447 - Que St. N.W. County

City or town Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mrs. Minta Foster

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Wid

6.(b) Name of husband or wife Orrin Foster Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 27, 1879

8. AGE: Years	Months	Days	If less than one day
68	6	2	..... hrs. ..... min.

9. Birthplace Council Bluff, Iowa (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name William J. Bamar

13. Birthplace Kentucky

MOTHER 14. Maiden name Mary Roberts

15. Birthplace Missouri

16. Informant Funeral records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/5/47 (month) (day) (year)

Cemetery or crematory Arlington Nat Cem

Location " Va

18. Funeral director S. H. Hines Co.

Address 2901 14th St. N.W.

19. 11/3 1947 Mrs E Jones Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1947 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1945 to Nov 3 1947 and that I last saw h.e.r. alive on Nov 2 1947

Immediate cause of death	DURATION
Generalized carcinomatosis	
Due to Primary Breast carcinoma	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. C. Anderson M.D. M. D. or other

Address Washington D.C. Date signed 11-3-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a 10178

Reg. Diat. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, Institution, or street address where death occurred: 415 - West Montg Ave
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Montgomery ave - West
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louis A. Gardiner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marie A. Gardiner
6.(c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) February 25 - 1860

8. AGE: Years	Months	Days	If less than one day
87	8	27	...hrs. ...min.

9. Birthplace Montg. County Maryland (Town, county, and state)
10. Usual occupation Farmer - Retired
11. Industry or business

FATHER
12. Name William F. Gardiner
13. Birthplace Maryland

MOTHER
14. Maiden name Maria Bowlen
15. Birthplace Maryland

16. Informant George W. Gardiner
Address Clarksville - Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 24/47 (month) (day) (year)
Cemetery or crematory St. Mary's Catholic Ch -
Location Barnesville - Montg Co - Md

18. Funeral director Wm. Reuben Pumphrey
Address Rockville - Maryland

19. 11/23/47 (Date rec'd by registrar) R. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1947, at 1 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/13 1941 to 11/22 1947 and that I last saw him alive on Nov 22 1947

Immediate cause of death Arteriosclerosis — DURATION
Cerebral hemorrhage
Due to Chronic Nephritis
Due to
Other conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C E Hawks M. D. or other
Address Rockville Md Date signed 11-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10179

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville, 100 Forest Avenue
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
100 Forest Avenue
How long in hospital or institution? No stay

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 100 Forest Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: ADA BOYD GLASSIE

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): September 29, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	15	____ hrs. ____ min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Daniel W. Classie
13. Birthplace: Buffalo, N. Y.

MOTHER
14. Maiden name: Minna Nash
15. Birthplace: Nashville, Tenn.

16. Informant: Henry H. Glassie, Jr.
Address: 6521 Brookville Rd., Chevy Chase

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18, 1947 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: Wm. Louden Dempsey
Address: Rockville, Maryland

19. November 18, 47 (Date rec'd by registrar) E P Thompson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1947, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to Nov. 14 1947 and that I last saw her alive on Nov. 1 1947.

	DURATION
Immediate cause of death: Probably coronary occlusion	Few minutes.
Due to:	
Due to: Arteriosclerosis, Myocarditis with cardiac Hypertrophy	5 years
Other conditions: Cholelithiasis, Blood Pressure	? 10 years

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. ____
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Wm. L. Leatherwood, M.D. (M. D. or other)
Address: Rockville, Md. Date signed: 11/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318

10180

CERTIFICATE OF DEATH

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town) Maryland.

How long in above place of death? Since Infancy

Hospital, Institution, or street address where death occurred: 8600 Old Georgetown Rd. Bethesda Hosp.

How long in hospital or institution? Since

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington. (If outside city or town limits, write RURAL and give nearest town)

Street No.: 3609 Cumberland St. N.W. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Sophie Goode

3.(b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Richard W. Goode-Dec.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct-20/1860.

8. AGE: Years: 87 Months: Days: 24 If less than one day: hrs. min.

9. Birthplace: Norfolk. Va. (Town, county, and state)

10. Usual occupation: House keeper.

11. Industry or business:

FATHER 12. Name: Marshal Parks.

13. Birthplace: Boston, Mass.

MOTHER 14. Maiden name: Sophie Jackson.

15. Birthplace: Virginia.

16. Informant: Dan Rhoads

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/14/47 (month) (day) (year)

Cemetery or crematory: Rock Creek Cem.

Location: Hyattsville D.C.

18. Funeral director: L. H. Jones Co.

Address: 2901 14th St. N.W.

19. 11/12 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17/November/1947. at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/November/1947 to 17/November/1947. and that I last saw h. alive on 17/November/1947 19

DURATION

Immediate cause of death: Nephritis chronic Uremia

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles R. E. Hadley M.D. M. D. or other

Address: 1801 Eye St N.W. Date signed: 17/Nov/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 10181

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
~~Hospital, institution~~, or street address where death occurred:
116 Park Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Montgomery
~~or town~~: 116 Park Ave.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Takoma Park Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Walter Albert Gregg.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Cora May Gregg
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): July 4 1879.

8. AGE: Years: 67 | Months: 4 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Leesburg (Town, county, and state) Va.
10. Usual occupation: Fruit & Agriculture
11. Industry or business: Park Admin. U.S. Gov.

FATHER
12. Name: Elijah Gregg
13. Birthplace: Loudoun County Va

MOTHER
14. Maiden name: Katherine Stevens
15. Birthplace: Loudoun County Va

16. Informant: Mrs. Dreyn K. Apperte
Address: 303 Ethan Allen Ave Takoma Park Md

17. BURIAL. Date thereof DEC - 2 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery ~~or crematory~~: ROCK CREEK
Location: WASHINGTON D.C.
18. Funeral director: Warren E Pumphrey
Address: SILVER SPRING MD
19. Dec 1 1947 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 29 1947 at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1947 to Nov 29 1947
and that I last saw him alive on Nov 29 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage.	11/29/47
Due to: Hypertension	3 yrs.
Due to: Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Howard [illegible] M.D. M. D. or other
Address: 28 Carroll Ave Takoma Park. Date signed 11/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10182

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney Montgomery (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours

Hospital, institution, or street address where death occurred: Montgomery County General Hospital

How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No.? (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Miss BERTHA HANSHEW

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JULY 14, 1885

8. AGE:

Years	Months	Days	If less than one day
62	3	22	hrs. min.

9. Birthplace: Frederick, Md. (Town, county, and state)

10. Usual occupation: Domestic work

11. Industry or business

FATHER

12. Name: Mr. HENRY HANSHEW

13. Birthplace: Frederick Maryland

MOTHER

14. Maiden name: Mary Mamott

15. Birthplace: Chainbridge Virginia

16. Informant: Mrs. William C. Ferguson

Address: Pleasant 8641 | 2901 Wheaton Rd. Kensington Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 8-12 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Frederick, Md.

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Md.

19. Nov 7 1947 (Date rec'd by registrar) Gertrude B Fawley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1947, at 10:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5 1947, to November 5 1947

and that I last saw her alive on November 5 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hours
Due to: Hypertensive Cardiovascular Disease	? yrs
Due to:	
Other conditions: Arteriosclerosis	? yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring, Md Date signed: 11/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 B x 10183

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery County

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14

Hospital, institution, or street address where death occurred:

Washington San. & Hospital

How long in hospital or institution? 14 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4709 8th st. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Bonnie Luckett Hockensmith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 1- 1873

8. AGE: Years	Months	Days	If less than one day
74	1	26	..... hrs. ..... min.

9. Birthplace: Frankfort Ky. (Town, county, and state)

10. Usual occupation: Editorial Clerk Tariff Commission Retired.

11. Industry or business

FATHER

12. Name: John T. Hockensmith

13. Birthplace: Frankfort Ky.

MOTHER

14. Maiden name: Ann Mary Taylor

15. Birthplace: Franklin Co. Ky.

16. Informant: W.S.H. Records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-47 (month) (day) (year)

Cemetery or crematory

Location: Frankfort, Ky.

18. Funeral director: W. H. Sines Co.

Address: 2901-14th St. N.W. Washington, D.C.

19. NOV. 28 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/27 1947, at 12:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/16 1947, to 11/27 1947

and that I last saw h.er alive on 11/27 1947

	DURATION
Immediate cause of death: Multiple pulmonary embolism.	5 min.
Due to: Carcinoma of the stomach, gastro-splenic ligament.	??
Due to:	
Other conditions: Pleural effusion - Ascites. Diarrhea. Ca. of omentum. (Include pregnancy within 3 months of death)	

Carcinoma of pancreas -

Major findings of operation: Limited Plastica. Date of op. June, 1947

Autopsy results: Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lionel Roth, M.D. M. D. or other

Address: Washington San. & Hosp. Takoma Park, Md. Date signed 11/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

10184 2 13
Reg. Dist. No.

1. PLACE OF DEATH:
County MONTGOMERY
City or town ROCKVILLE
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: CHESTNUT LODGE SANITARIUM.
Stay in hospital or inst. (yrs., or mos., or days) 3 years, 8 months, 22 ds.
Stay in this community (yrs., or mos., or days) life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY.
City or town Darnestown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. None
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME: WILLIAM ALBERT JONES

3. (b) Social Security Number: None

4. Sex: MALE
5. Color or race: WHITE
6. (a) Single, married, widowed, or divorced: SINGLE.
6 (b) Name of husband or wife: None
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) May 7, 1857
8. AGE: Years 90 Months 6 Days 6 If less than one day ____ hrs. ____ min.
9. Birthplace Darnestown, Maryland (Town, county, and state)
10. Usual occupation FARMER (Retired)
11. Industry or business Farming
FATHER 12. Name Z. Nathan Jones
13. Birthplace Montgomery Co., Maryland
MOTHER 14. Maiden name Eleanore West
15. Birthplace Montgomery Co., Maryland
16. Informant Miss Margaret Jones (Neice)
Address Darnestown, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1947 (month) (day) (year)
Cemetery or crematory St. Marys Churchyard
Location Rockville, Maryland
18. Funeral director Wm Reuben Humphrey
Address Rockville, Maryland
19. Nov. 14, 1947 (Date rec'd by registrar) W P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 13, 1947, at 6:10 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from OCT. 1, 1946, to NOV. 13, 1947, and that I last saw h[illegible] alive on NOV. 13 1947

Immediate cause of death	DURATION
ACUTE HEART FAILURE.	15 mts.
Due to ARTERIOSCLEROTIC HEART DISEASE	10 years
Due to SENILITY etc.	
Other conditions DIABETES MELLITUS	10 years

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph W. Coke, M. D.
M. D. or other
Address Chestnut Lodge Rockville, Md. Date signed 11/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a 10185

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Maple Ridge Rd.,

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME Infant Girl Joyce

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov. 7, 1947

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
17 Min. 0	0	0		17

9. Birthplace: Bethesda, Montgomery, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER 12. Name: William Joyce

13. Birthplace: Scranton, Pennsylvania

MOTHER 14. Maiden name: Margaret Connell

15. Birthplace: Scranton, Pennsylvania

16. Informant: William Joyce

Address: Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 8, 1947 (month) (day) (year)

Cemetery or crematory: St. Marys Cemetery

Location: Rockville, Maryland

18. Funeral director: Wm. Randem Rumphrey

Address: Bethesda, Maryland

19. 11/7 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/7 1947, at 6:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/7 1947 to 11/7 1947 and that I last saw h[illegible] alive on 11/7 1947

Immediate cause of death	DURATION
Congestive failure	Born 6:30 am 11/7/47
Due to: Cerebral hemorrhage probable	Died 6:47 am 11/7/47
Due to: Placenta, Premature sep. of (Normal implantation)	
Other conditions: Chloroform, morphine, Luminal.	

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Almat B Kelly M. D. (M. D. or other)

Address: 8237 Georgia Ave Silver Spring, Md. Date signed: 11/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

10186

Reg. Diat. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 8 months

Hospital, institution, or street address where death occurred:
Chestnut Lodge

How long in hospital or institution? 3 years, 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Florida County Pinellas

City or town St. Petersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. None
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Ketchum, Georgina P.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife ? Ketchum

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown 1870

8. AGE: Years: Approx. 77 | Months: 6 mos. | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Secretary

11. Industry or business

FATHER 12. Name PFlaum

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Miss Evelyn Necarsulmer
Address 1130 Park Ave. N.Y. (Distant Cousin)

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 11-28-47 (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Washington, D.C.

18. Funeral director Wm. Reubum Pumphrey

Address Rockville, Maryland

19. 11-28 1947 (Date rec'd by registrar) E. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Nov Nov 1947, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h.er alive on 27 Nov 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to arteriosclerotic changes in blood vessels	
Due to senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Stanley H. Eldut M.D.
M. D. or other

Address Chestnut Lodge. Rockville, Md. Date signed 11-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 a

10187

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Germantown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Germantown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hilton H. Kirby

3.(b) Social Security Number 705-12-3733

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary E. Kirby
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Feb - 2 - 1876

8. AGE:

Years	Months	Days	If less than one day
71	9	10	...hrs. ...min.

9. Birthplace: Bristol, Virginia (Town, county, and state)
10. Usual occupation: Telegraph Operator
11. Industry or business: C. & O. Rail Road
12. FATHER — Name: Silas Riley Kirby
13. FATHER — Birthplace: Jefferson - Va
14. MOTHER — Maiden name: Anna E. Carver
15. MOTHER — Birthplace: Jefferson Va
16. Informant: Mary E. Kirby
Address: Jefferson - Va
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/15/47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet.
Location: Frederick md -
18. Funeral director: Ernest C Gaskyn
Address: Gaithersburg md -
19. Nov. 12 1947 (Date rec'd by registrar) Alonzo G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov - 12 1947 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April - 1 - 1946 to Nov - 12 - 1947 and that I last saw him alive on Oct - 11 - 1947

Immediate cause of death	DURATION
Cardio - nephritis	19 months
Due to	
Due to	
Other conditions: Chronic pyelitis	30 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gillian Wells, M.D. M. D. or other
Address: Gaithersburg Md Date signed Nov. 12 - 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10514

4629

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2-17

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: OLNEY

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, institution, or street address where death occurred:

Montgomery County General Hospital

How long in hospital or institution? 36 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ALEX MACABEE

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: [illegible] years

7. Birth date of deceased (mo., day, yr.): March 20, 1871

8. AGE: Years: 76 | Months: 8 | Days: 2. | If less than one day: hrs. min.

9. Birthplace: Montgomery, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: John Macabee

13. Birthplace: Montgomery, Maryland

MOTHER

14. Maiden name: Helen Prather

15. Birthplace: Montgomery, Maryland

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 24-1947 (month) (day) (year)

Cemetery or crematory: Brooke Grove Md

Location: Montgomery Co Md

18. Funeral director: Roy W. Barber

Address: Gaithersville Md.

19. Nov. 23 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22, 1947, at 4 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 22, 1947, to November 22, 1947 and that I last saw h... alive on November 2..., 1947

Immediate cause of death	DURATION
Carcinoma of Rectum	? Months
Due to	
Due to	
Other conditions: Generalized arteriosclerosis	? years

(Include pregnancy within 3 months of death)

Major findings of operations: Multiple metastases to colon and peritoneum. Date of op. 10- -47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring, Md Date signed: 11/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10188

180

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Vernon Martin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 13 1929

8. AGE: Years 18 | Months 4 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Frederick, Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Robert Martin
13. Birthplace Md

MOTHER 14. Maiden name Estha Mason
15. Birthplace Md

16. Informant Robert Martin
Address Frederick Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26 1947 (month) (day) (year)
Cemetery or crematory Takoma Park Md
Location Frederick Md

18. Funeral director Robt L. Snyder & Son
Address 246 - N. Wash. St Rockville Md

19. 11-25-47 (Date rec'd by registrar) 19 Mrs E. L. Thompson Registrar
per Frank Hurley

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 19 47 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1947 to case 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Extensive burns (accidental)	died instantly
Due to	
Body found in ashes of home in which had completely burned	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? Travilah (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Fire Injured at work? no

23. SIGNATURE Frank J. Broschart M.D. M. D. or other
Address Dept. Med. Exam. Md Date signed 11-24-47

VS/A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10189

CERTIFICATE OF DEATH

Reg. Dist. No. 2-16

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: BETHESDA
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:
5523 JOHNSON AVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: BETHESDA
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5523 JOHNSON AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: PHILIP S. MATTHEWS

3.(b) Social Security Number: 367-01-8076

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: SARA BRANHAM.

7. Birth date of deceased (mo., day, yr.): Aug 14 1883 6.(c) If alive, give age ..... years

8. AGE: Years: 64 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: MIDLAND MICH
(Town, county, and state)

10. Usual occupation: REALTOR

11. Industry or business

FATHER
12. Name: PHILIP S. MATTHEWS
13. Birthplace: CANADA

MOTHER
14. Maiden name: SARA HUGHES
15. Birthplace: MICH

16. Informant: Sara B. Matthews

Address: 5523 Johnson ave. Bethesda Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 (month) 24 (day) 1947 (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md.

18. Funeral director: Jos. Sawkins Funeral Home

Address: 7956 Penn. Ave. Wash. D.C.

19. 11/23 (Date rec'd by registrar) 19 47 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 21 19 47 at 8:20 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1, 1947, to Nov 21 1947

and that I last saw h wife alive on Nov 21 1947

Immediate cause of death	DURATION
Myocardial infarction	
Due to: Coronary Thrombosis	14 hrs
Due to:	
Other conditions: Hypertension	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C W Daughton MD
M. D. or other

Address: 2011 R St NW Washington DC Date signed: 11/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10190

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5736 3rd St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: MC CONNELL, George Joseph

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male (MALE)	W-US	married

6.(b) Name of husband or wife: Anna Francis McConnell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1881

8. AGE: Years: 66 | Months: 4 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Mo.
(Town, county, and state)

10. Usual occupation: Motion Picture Operator

11. Industry or business:

FATHER
12. Name: MC CONNELL, Thomas J. dec.
13. Birthplace: Mo.

MOTHER
14. Maiden name: AUDRAIN, Elizabeth dec.
15. Birthplace: Ind.

16. Informant: wife: Mrs. Anna F. McConnell
Address: 5736 3rd St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-21-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Hines Funeral Director W.A.S.
Address: 2901 14th St., NW, Washington, D.C.

19. 11-18- 1947 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 November 19 47 at 4:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 November 19 47 to 18 November 19 47 and that I last saw h im alive on 18 November 19 47

	DURATION
Immediate cause of death: Hypertensive Heart Disease	several yrs.
Due to: Bronchopneumonia	2 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Hypertensive Heart Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. A. Dinsmore Jr. W. A. DINSMORE, Jr., Lt. Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-18-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

176

10191

CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6hours 20 minutes

Hospital, institution, or street address where death occurred:
USNH, NNMC, Bethesda, 14, Maryland

How long in hospital or institution? 6 hours 20minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Rhode Island County:

City or town: Centrall Falls
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Perry Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

MC DONALD, Charles Rydolph

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10-3-29

8. AGE: Years	Months	Days	If less than one day
18	1	3	hrs. min.

9. Birthplace: Central Falls, Rhode Island
(Town, county, and state)

10. Usual occupation: U.S. Navy

11. Industry or business

FATHER
12. Name: Charles McDonald
13. Birthplace: Rhode Island

MOTHER
14. Maiden name: Gladys Irene Lazotte
15. Birthplace: Rhode Island

16. Informant: father: Mr. Charles McDonald

Address: 6 Perry St., Central Falls, R.I.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Notre Dame

Location: Pawtucket, Rhode Island

18. Funeral director: W. W. Chambers Co. E. & M.

Address: 1400 Chapin St. NW, Washington, D.C.

19. 11-30 19 47 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 November 19 47 at 8:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. med. Exam Coro 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture of skull	7 hrs.
Due to: Fall from Traction	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 11-29-47

Where did injury occur? Concordia (City or town) DC. (County) (State)

Injured at home, farm, industry, public place (where?) U.S.N.

Means of injury: Fall Injured at work? Yes

23. SIGNATURE: Frank J. Bouchat M.D.
Dep. Med. Exam M. D. or other

Address: Gaithersburg Md Date signed 11-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

827

10192

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

#1 Takoma Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. #1 Takoma Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME DANIEL MILLER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mabel H. Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 5, 1861

8. AGE: Years	Months	Days	If less than one day
86	4	5	..... hrs. ..... min.

9. Birthplace Oakland, Maryland (Town, county, and state)

10. Usual occupation Retired U.S.P.O. Employee

11. Industry or business Government

FATHER

12. Name Unknown

13. Birthplace Unknown

MOTHER

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Mabel H. Miller

Address #1 Takoma Ave, Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 13, 1947 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Rock Creek Church Rd, Washington, DC

18. Funeral director J. Arthur Walters

Address 754 Eleventh St NW Wash. D.C.

19. Nov. 11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 19 47 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9 19 47 to Nov 10 19 47

and that I last saw h alive on Nov 9 19 47

Immediate cause of death Cerebral embolism — DURATION 2½ hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brockhaus M.D. Dep. Med Exam. M. D. or other

Address Gaithersburg Md Date signed 11-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

× 10193

45 f

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 10 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 6 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 803 7th St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI ✓

3.(a) FULL NAME: MORAN, Martin Aloysius

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 5, 1894

8. AGE: Years	Months	Days	If less than one day
53	1	29	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: unemployed
11. Industry or business:

FATHER
12. Name: MORAN, Corneluis dec
13. Birthplace: Ireland C.

MOTHER
14. Maiden name: DONOUGH, Katherine dec
15. Birthplace: Wash., D.C.

16. Informant: sister: Mrs. Mary A. Baness
Address: 803 7th St., N.E., Wash., D.C.

17. burial — Date thereof: 11-8-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington, D.C.

18. Funeral director: Hanlon Funeral Home Wak
Address: 611 H St., N.E., Wash., D.C.

19. 11-5 19 47 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 19 47 at 12:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 19 47 to 4 Nov. 19 47 and that I last saw him alive on 4 November 19 47

	DURATION
Immediate cause of death: massive cerebral embolism	minutes
Due to: Rupture right external carotid Chemangioma	2 hrs
Due to: Erosion, probably from irritation	2 hrs
Other conditions: Carcinoma, tongue	1 yr

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma, base of tongue & right ant. pillar tonsil Date of op.
Autopsy results: Erosion rt ext. carotid c necrosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. J. Delaney / A. J. DELANEY Capt. MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 11-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10194

195

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 10-26/47
Hospital, institution, or street address where death occurred: Out of an Hosp
£600 Old Georgetown Rd. Bethesda
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Cedar Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. Gaithersburg
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Ira W. Mullinix

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Edith Mullinix
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72	1	30	..... hrs. ..... min.

9. Birthplace Montgomery County, Maryland
(Town, county, and state)
10. Usual occupation Hunter
11. Industry or business Farming
FATHER 12. Name James H. Mullinix
13. Birthplace Cedar Grove, Maryland
MOTHER 14. Maiden name Mary Young
15. Birthplace Montgomery Co., Md.
16. Informant Ada Main
Address Cedar Grove, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 13, 1947 (month) (day) (year)
Cemetery or crematory Salem Union Cemetery
Location Cedar Grove, Md.
18. Funeral director Roy W. Barber
Address Laytonsville Md.
19. 11/11 (Date rec'd by registrar) 1947 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/ 1947 at 6.25 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Dep. Med. Exam. Case	
Autopsy, Withheld	?
Pleas for Report	?
Due to	.....
.....	.....
Due to	.....
.....	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results Withheld
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10/26/47
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE Dr. Bird Affirmed Path.
M. D. or other
Address Sandy Spring Md. Date signed 11/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

10195

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Mo. 21 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 Month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: The Plains
(If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war: WWI & Sp.&Am.

3.(a) FULL NAME: OSBORN, Solomon (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 22, 1873

8. AGE: Years	Months	Days	If less than one day
74	5	2	hrs. min.

9. Birthplace: W. Va.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: OSBORN, Solomon dec.

13. Birthplace: Va.

MOTHER — 14. Maiden name: NICHOLS, Sue dec.

15. Birthplace: Va.

16. Informant: wife: Mrs. Pearl Osborn, The Plains,
Address: Virginia

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS.

Address: 3072 M St., N.W., Wash., D.C.

19. 11-25 (Date rec'd by registrar) 19 47 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 November 19 47, at 11:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3 19 47 to 24 Nov. 19 47 and that I last saw him alive on 24 November 19 47

Immediate cause of death	DURATION
CORONARY THROMBOSIS AND	2 wks
CEREBRAL INFARCTION AND ABSCESS	
Due to	
Due to	
Other conditions: BRONCHOPENUMONIA BILATERAL (Include pregnancy within 3 months of death)	1 wk

Major findings of operations: CALCULUS URINARY BLADDER

Date of op.:

Autopsy results: CEREBRAL INFARCTION AND ABSCESS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: T. N. Quilter Injured at work?

23. SIGNATURE: T. N. QUILTER, Lt. JG MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161c 10196

CERTIFICATE OF DEATH

Reg. Dist. No. 2-16

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Suburban Hospital

How long in hospital or Institution? 16 hrs and 10 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Weaver's Farm. Bell mills Road.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Earl Palmer.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife Charles Henry Wilson

6.(c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.) November 8. 1947

8. AGE: Years	Months	Days	If less than one day
		7	9 hrs. 10 min.

9. Birthplace Bethesda, Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Charles Henry Wilson

13. Birthplace Scotland. Maryland.

MOTHER 14. Maiden name Marguerite Palmer

15. Birthplace Washington. D.C.

16. Informant Mother - Marguerite Palmer.

Address Box 5822. Bethesda, Maryland.

17. Cremation Date thereof Nov 19 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Suburban Hospital

Location Bethesda 14 Md

18. Funeral director A. B. Solow / supt

Address Bethesda 14 md

19. 11/24 1947 Mrs E Jobes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1947, at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Erythroblastosis Fatalis.	
Due to	
Due to	
Other conditions Dehydration Fatalis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David M. Hobart M. D. or other

Address 5402 Connecticut Ave Washington. D.C. Date signed 11/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
NOV 26 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

51 L

10197

Reg. Diat. No. 216

1. PLACE OF DEATH:

County MONTGOMERY

City or town BETHESDA
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: SUBURBAN HOSPITAL - 8600 OLD GEORGETOWN Road

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 629 Sligo Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MERTON PEARRE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of ~~husband or~~ wife HALLIE N PEARRE

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 20, 1871

8. AGE: Years 75 | Months 11 | Days 19 | If less than one day ____ hrs. ____ min.

9. Birthplace UNIONVILLE, MARYLAND
(Town, county, and state)

10. Usual occupation PHYSICIAN

11. Industry or business

FATHER
12. Name WILLIAM H. PEARRE
13. Birthplace Unionville, MARYLAND.

MOTHER
14. Maiden name RUTH BUCKINGHAM
15. Birthplace CARROLL COUNTY, MARYLAND

16. Informant Wife MRS. HALLIE N. PEARRE

Address 629 SLIGO AVE. SILVER SPRING, MD

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 11-4-47 (month) (day) (year)

Cemetery ~~or crematory~~ LINGANORE

Location Unionville, Frederick Co. Md.

18. Funeral director C. M. Watts

Address Wenfield Md

19. 11 2 1947 (Date rec'd by registrar) Wm E Adler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1947, at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 29 1947 to Nov. 1 1947

and that I last saw h~~im~~ alive on Nov. 1 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions Carcinoma of Prostate	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Marion Bamford M.D.
M. D. or other

Address 9001 Sutton rd. Silver Spring, Md. Date signed 11/2/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

159 10198

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: OLNEY
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
The MONTGOMERY COUNTY GENERAL HOSPITAL
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. # 2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME ~~Baby Girl Dyson~~ Diana Elizabeth Plummer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1947

8. AGE: Years	Months	Days	If less than one day
—	—	10	hrs. min.

9. Birthplace: OLNEY, MONTGOMERY, MARYLAND
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: RUSSELL PLUMMER
13. Birthplace: Stewartstown, Maryland

MOTHER
14. Maiden name: MARGARET LOUISE DYSON
15. Birthplace: Gaithersburg, MARYLAND

16. Informant: MARGARET LOUISE DYSON
Address: Gaithersburg, MD. R. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov (mooth) (day) (year)
Cemetery or crematory: Brooke Grove mem
Location: Laytonsville mem
18. Funeral Director: Roy W. Barham
Address: Laytonsville, Md

19. Nov 15 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15 1947, at 8:02 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
NOVEMBER 6 1947, to November 15 1947
and that I last saw her alive on 11-15. 1947

Immediate cause of death	DURATION
Depression of Respiratory Center	8 hours
Due to: ? Cerebral oedema	8+ hours
Due to: Prematurity	10 days
Other conditions: Pregnancy of Mother	10 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or towo) (Couoty) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles H. Ligon M.D.
M. D. or other
Address: Sandy Spring, Md. Date signed: 11/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10199

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County MONTGOMERY
City or town CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 YEARS
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6503 CONN AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LE ROY ATKINS PORTER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife RUSSELL PORTER
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT 17 1883

8. AGE: Years	Months	Days	If less than one day
64			hrs. ..... min.

9. Birthplace JACKSONVILLE, ALABAMA (Town, county, and state)
10. Usual occupation INTER STATE COMM COMM
11. Industry or business

FATHER
12. Name CHRISTOPHER J PORTER
13. Birthplace ALA

MOTHER
14. Maiden name ANNIE T PRIVETT
15. Birthplace ALA

16. Informant MR. LE ROY A PORTER JR.
Address 6503 CONN. AVE, CHEVY CHASE
17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec 1 1947 (month) (day) (year)
Cemetery or crematory
Location Jacksonville, Alabama
18. Funeral director W W Chamber Co
Address 3072 M St NW Washington D C
19. 12/1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30th 1947, at 5-00 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Past 10 years 19.. to 11/30 1947
and that I last saw h.. alive on week of 11/17 1947

Immediate cause of death	DURATION
Pulmonary Edema	
Acut Cardiac Decompensation	11 hours
Due to Chronic hypertension & arteriosclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 11-1016-16th St NW Date signed 11/30/47

over

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2

Patient was dead on arrival

Patient was seen alive in my D.C. office during week of 11/17/47. He had been under frequent care for hypertension during the past five years.

Case was cleared through Police and Coroner's Office by Phone.

W. S. Blanks

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10200

50

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

9104 Colesville Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9104 Colesville Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. MARY WALKER PRENTISS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Fred R.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 27th. 1897

8. AGE: Years	Months	Days	If less than one day
49	4	18	..... hrs. ..... min.

9. Birthplace Ohio (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William H. Walker

13. Birthplace Ohio

MOTHER 14. Maiden name Mary Alice Kress

15. Birthplace Ohio

16. Informant Mr. Fred R. Prentice

Address 9104 Colesville Rd. Sil. Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 17th. 47 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Prince Georges Co. Md.

18. Funeral director Howard E. Dunphrey

Address Silver Spring, Md.

19. Nov. 17 1947 (Date rec'd by registrar) Josephine Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1947, at 10:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Nov. 15 1947

and that I last saw h er alive on Nov. 14-47 11.30 p.m. 19

Immediate cause of death	DURATION
pneumonia	
Due to Ca of Breast	
Due to with Metastases to Lung + Liver	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations 1943 Cancer of left Breast Date of op. Feb.

Autopsy results Sibley hosp.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Richard B. Phillips M.D. M.D. or other

Address 8248 Georgia Ave Silver Spring Md. Date signed 11-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

10201

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 yrs
Hospital, institution, or street address where death occurred:
8605 Burdette Road,
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda 14,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8605 Burdette Road,
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME
* * * * * * ELIZA CLARK PUGH * * * * * * * * * * * * *

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Charles Pugh (deceased)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 13, 1859

8. AGE: Years	Months	Days	If less than one day
87 87	11	13	— hrs. — min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business None

FATHER
12. Name John Phillips
13. Birthplace Virginia

MOTHER
14. Maiden name Matilda Golispie
15. Birthplace Virginia

16. Informant Mr. Richard E. Pugh (son)
Address Bethesda 14, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 28, 1947 (month) (day) (year)
Cemetery ~~Kensico~~ Bethesda Presbyterian church
Location Bethesda, Maryland

18. Funeral director Wm. Reuben Sumphrey
Address Bethesda 14, Maryland

19. 11-27-47 (Date rec'd by registrar) 19..... Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26th, 1947 at 1:15P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18, 1947 to Nov 26, 1947
and that I last saw h[illegible] alive on Nov 26, 1947.

	DURATION
Immediate cause of death Cardiac insufficiency	3 days
Due to Chr. generalized arterio-sclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Emil P. Bamforth M.D.
Address 7345 Wisconsin Ave., Bethesda, Maryland M. D. or other
Date signed 11/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

51 L

10202

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 27 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4901 Tilden St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: RAINIER, Norman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Rosita Rainier

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 6, 1888

8. AGE: Years	Months	Days	If less than one day
59	0	8	hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Retired Marine Corps

11. Industry or business:

FATHER

12. Name: RAINIER, Nelson K. dec.

13. Birthplace: England

MOTHER

14. Maiden name: Florence ? dec.

15. Birthplace: England

16. Informant: Wife: Mrs. Rosita Rainier

Address: 4901 Tilden St., N.W. Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-18-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES

Address: 2901 14th St., N.W., Wash., D.C.

19. 11-14-47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 November 1947, at 11:39 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 April 1947 to 14 Nov. 1947 and that I last saw h... im alive on 14 November 1947

	DURATION
Immediate cause of death: Cardiac Failure	3 weeks
Due to: Coronary Heart Disease	5 yrs +
Due to: Carcinoma Prostate with metastasis to liver	?
Other conditions: Left pyelonephritis	1 yr.
Pulmonary Embolism	1 mo.

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Carcinoma Prostate, Coronary Art. Dis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: N O

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Phillip A. Bates M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-14-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108 10203

CERTIFICATE OF DEATH

Reg. Diat. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. Burnt Mills Hills
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Martha Agnes Reeves

3.(b) Social Security Number: None

4. Sex: Fe
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: James C Reeves
6.(c) If alive, give age: 83 years
7. Birth date of deceased (mo., day, yr.): April 17 1864
8. AGE: Years: 83 Months: 6 Days: 25 If less than one day: hrs. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:
FATHER 12. Name: William Fraser
13. Birthplace: Virginia
MOTHER 14. Maiden name: Martha Howison
15. Birthplace: Virginia
16. Informant: Mr. Wallace Reeves
Address: Silver Spring Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery.
Location: Suitland Md.
18. Funeral director: J. William Leis Sons
Address: 300-4th St N.E. Wash. D.C.
19. Nov 13 1947 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12, 1947, at P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 1947, to Nov 12 1947
and that I last saw her alive on Nov 12 1947

	DURATION
Immediate cause of death: Pneumonia, lobar	4 days
Due to: Multiple Sclerosis	Several months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other
Address: 9601 Colesville Rd Silver Spring Md. Date signed 11-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10523

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2/3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Potomac (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred: Rockville, R.F.D.#2

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Potomac (If outside city or town limits, write RURAL and give nearest town)

Street No. Rockville, R.F.D.#2 (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Ira Sylvester Ricketts

3.(b) Social Security Number: Yes-Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth S. Ricketts

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): December 4, 1888

8. AGE:

Years	Months	Days	If less than one day
58	11	26	... hrs. ... min.

9. Birthplace: Potomac, Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: None

FATHER

12. Name: Edward C. Ricketts

13. Birthplace: Potomac, Maryland.

MOTHER

14. Maiden name: Leeanna Baker

15. Birthplace: Unknown

16. Informant: Mrs. Elizabeth S. Ricketts

Address: Potomac, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 4, 1947 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda, Maryland.

19. 12-4 19 47 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 30 19 47, at 8:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 47, to Dec 4 19 47, and that I last saw h alive on Dec 4 19 47

Immediate cause of death	DURATION
(a) Coronary occlusion	died suddenly
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Bouchart M.D. Dep. med. Exam. M. D. or other

Address: Smithsburg Md. Date signed 12-4-47

10513

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

Reg. Diat. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Rural R.F.D. Clarksburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural R.F.D. Clarksburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Vina F. Ricketts

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Robert S. Ricketts

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) April 24 - 1887

8. AGE: Years	Months	Days	If less than one day
60	6	29	hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business Home

FATHER 12. Name Samuel Speak

FATHER 13. Birthplace Frederick Co Md

MOTHER 14. Maiden name Offie J

MOTHER 15. Birthplace

16. Informant Robert S. Ricketts

Address Montgomery Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 24, 1947 (month) (day) (year)

Cemetery or crematory Mt Carmel

Location Montgomery Co Md

18. Funeral director Rev W Barber

Address Poolesville Md

19. Nov 23 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947 at 6.15 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Nov 22 1947 and that I last saw h-- alive on Nov 22 1947

Immediate cause of death	DURATION
Myocarditis	3
Endocarditis	
Chr Interstitial Nephritis	3
Due to Nephritis Diabetes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.B. Steward M. D. or Other

Address Laurel Date signed 11/25/47

10512

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Potomac
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:
R.F.D. #2 Rockville,

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: R.F.D. #2, Rockville (Potomac)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #2
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME

********** NINA DOVE SAUNDERS **********

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James H. Ricketts

6.(c) If alive, give age: dec. years

7. Birth date of deceased (mo., day, yr.): November 10th, 1876

8. AGE: Years	Months	Days	If less than one day
71 71	0	20	... hrs. ... min.

9. Birthplace: Leesburg, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Jack Dove
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elizabeth Poole
15. Birthplace: Virginia

16. Informant: Mrs. Elizabeth S. Ricketts

Address: RFD#2, Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 4, 1947 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Maryland

18. Funeral director: Wm. Reardon Pumphrey

Address: Bethesda, Marylnd

19. 12-4 (Date rec'd by registrar) 1947 O. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30th 1947 at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
DEP. MED. EXAM. CASE	Died suddenly
Due to: Acute cardiac Dilitation	Instant
Due to: Chronic myocarditis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: As shown above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: [illegible] Asst Pub Hlth Dept M. D. or other

Address: Sandy Spring, Md. Date signed: 12/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 10204

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 22 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 1 month, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: An. Ar.

City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME

SHANK, Norman Harold

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Dorothy M. Shank

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1 April 1903

8. AGE: Years	Months	Days	If less than one day
44	7	6	..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: Michael Shank
13. Birthplace: Pennsylvania, deceased

MOTHER
14. Maiden name: Daisy Butts
15. Birthplace: Virginia, deceased

16. Informant: Wife: Mrs. Dorothy M. Shank
Address: Edgewater, Maryland

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: 11-21-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co. W.J.T.

Address: 1400 Chapin St., NW, Washington, D.C.

19. 11-8 19 47 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 November 19 47 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-16- 19 47 to 11-7 19 47 and that I last saw him alive on 11-7- 19 47

	DURATION
Immediate cause of death: Sudden Severe Coronary occlusion	5 min
Due to: Coronary Thrombosis (Angina Pectoris)	1 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: H.L.C.Stevens Jr. H.L.C.STEVENS, JR., LTJG MC USNR
M. D. or other

Address: USNH, Bethesda, Md. Date signed: 11-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10206

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 805 Quackenbos Street, Northwest
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME

SHOR, Louis (n)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Sarah Shor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10 June 1897

8. AGE: Years	Months	Days	If less than one day
50	5	20	hrs. min.

9. Birthplace: Austria
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER — 12. Name: Hyman Shor

13. Birthplace: Austria, deceased

MOTHER — 14. Maiden name: Hannah Laufer

15. Birthplace: Austria, deceased

16. Informant: Wife: Mrs. Sarah Shor

Address: 805 Quackenbos St., NW, Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-1-47 (month) (day) (year)

Cemetery or crematory: George Washington Memorial

Location: Maryland

18. Funeral director: Goldberg Funeral Home C.J.G.

Address: 4217 9th St., NW, Washington, D.C.

19. 12-1-47 (Date rec'd by registrar) 19 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 November 19 47 at 11:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-10- 19 47 to 11-30- 19 47 and that I last saw h im alive on 11-30- 19 47

Immediate cause of death	DURATION
Coronary thrombosis	24 hrs.
Due to: Coronary occlusion	24 hrs.
Due to: Hypertensive Cardio Vascular Disease	Several years.
Other conditions: Acidosis + Uremia due to recent long standing hypertension [6/6/47 also]	2-3 wks

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. E. BILLMAN, LTJG MC USN
M. D. or other

Address: USNH, Bethesda, Md. Date signed: 12-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10205

108

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 481 L St., S.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: SIMON, Andrew (n)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5, 1893

8. AGE: Years	Months	Days	If less than one day
54	4	21	hrs. min.

9. Birthplace: S.C.
(Town, county, and state)

10. Usual occupation: unemployed

11. Industry or business

FATHER — 12. Name: Simon, Eli dec.

13. Birthplace: S.C.

MOTHER — 14. Maiden name: Cooi, Sally dec.

15. Birthplace: S.C.

16. Informant: sister-inplaw: Mrs. Agnes Smalls

Address: 481 L St., S.W., Wash., D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof 11-26-47 (month) (day) (year)

Cemetery or crematory:

Location: Bishopville, S.C.

18. Funeral director: Barnes & Matthews E74

Address: 612-614 Fourth St., S.W., Wash., D.C.

19. 11-26 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 19 47 at 9:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 November 19 47 to 26 November 19 47 and that I last saw him alive on November 26 19 47

Immediate cause of death	DURATION
Lobar Pneumonia	Under
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Lobar Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. L. FLECK, Lt. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

77c

10207

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:-

County: Montgomery

City or town: Colesville Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersville Rfd

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Lillian Young Small

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Clarence H Small

7. Birth date of deceased (mo., day, yr.): Dec 7-1897

6.(c) If alive, give age ..... years

Dec 7-1897

8. AGE:

Years	Months	Days	If less than one day
49	11	4	..... hrs. ..... min.

9. Birthplace: Sugar Grove Va (Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business: Home

FATHER

12. Name: John Young

13. Birthplace: Smith Co Va

MOTHER

14. Maiden name: Grace Gorman

15. Birthplace: Smith Co Va

16. Informant: Clarence H Small

Address: Gaithersburg, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: NOV 13-1947 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington D C

18. Funeral director: Guy W. Barker

Address: Colesville md

19. NOV 12 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV 11 19 47, at 2:00 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 3rd 1947 to 19..... and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral edema	3 days
Due to acute alcoholism	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J Bosciart M.D. Coroner M. D. or other

Address: Gaithersburg md Date signed 11-11-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10208

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Washington County: D C

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 624 E St N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William H. Snellings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: Years: 79 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Fredricksburg, Va. (Town, county, and state)

10. Usual occupation:

11. Industry or business: Retired

FATHER 12. Name: Robert Snellings

13. Birthplace: Va.

MOTHER 14. Maiden name: Margaret Mullen

15. Birthplace: Va.

16. Informant: Mrs. J. W. Wright (niece)

Address: 1320 Locust Rd. N.W. Wash

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/24/47 (month) (day) (year)

Cemetery or crematory:

Location: Fredericksburg, Va

18. Funeral director: W. W. Chandlee

Address: Wash. D.C

19. 11/27 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 1947, to Nov 22 1947

and that I last saw him alive on Nov. 22 1947

	DURATION
Immediate cause of death: acute cardiac decompensation	2 wks
Due to:	
Due to:	
Other conditions: Chronic Cardio-Vascular renal disease	4 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel B. Washington M.D. M.D. or other

Address: 6234 Georgia Ave NW Wash. D.C. Date signed: 11/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

309

10209

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James H. Snowden

3.(b) Social Security Number

4. Sex: male

5. Color or race: C

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of ~~husband or~~ wife: Jennette Snowden

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): June 7 1888

8. AGE: Years 59 Months 5 Days If less than one day hrs. min.

9. Birthplace: Howard (Town, county, and state) Maryland.

10. Usual occupation: Laborer.

11. Industry or business

FATHER 12. Name: George R. Snowden

13. Birthplace: Howard Co., Md.

MOTHER 14. Maiden name: Alice Fisher

15. Birthplace: Baltimore, Md

16. Informant: Jeanette Snowden (wife)

Address: Rockville, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 14 1947 (month) (day) (year)

Cemetery or crematory: Church Cemetery

Location: Rockville, Maryland.

18. Funeral director: E. F. Snowden

Address: 246 N. Washington St. Rockville

19. Nov. 14 1947 (Date rec'd by registrar) Gertrude B Fawcett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11 1947, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1946, to Nov. 11 1947 and that I last saw h[illegible] alive on Nov 11 1947

Immediate cause of death: Coronary Thrombosis — DURATION

Due to: Embolus

Due to: Gastric Gummata

Other conditions: Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Webster Lovell M.D. M. D. or other

Address: Rockville Md. Date signed Nov 12 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10210

CERTIFICATE OF DEATH

Reg. Dist. No. 2-17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 days

Hospital, institution, or street address where death occurred: Montgomery County Gen'l Hosp.

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: (Rural) Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD #1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME CHARLES E. STEPHENS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 22, 1867

8. AGE: Years: 80 | Months: 7 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Va.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER 12. Name: CHARLES E. STEPHENS

FATHER 13. Birthplace: Va.

MOTHER 14. Maiden name: Nora B Talbott

MOTHER 15. Birthplace: Fredrick Co., Md.

16. Informant: Hospital Records

Address: Sandy Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 21 1947 (month) (day) (year)

Cemetery or crematory: Monocacy Cem

Location: Montgomery Co

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda, Maryland

19. Nov 18 1947 (Date rec'd by registrar) Geo. Leslie B. Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18 1947 at 8° P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1947 to Nov 18 1947

and that I last saw h. alive on Nov 18 1947

Immediate cause of death	DURATION
Cerebrovascular accident +	5 hr
Due to: Coronary Occlusion	
Due to: Arteriosclerotic Heart Disease	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles W. Tyson M.D.

M. D. or other

Address: Sandy Spring, Md. Date signed: 11/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157f

10211

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery Co.
City or town Takoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days 4 hr 55 min
Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital
How long in hospital or institution? 5 days 4 hr 55 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Germantown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Douglas Lee Stevens

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: —
6.(b) Name of husband or wife: —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): November 4. 1947

8. AGE: Years — Months — Days 5 — If less than one day: 4 hrs. 55 min.

9. Birthplace Washington San & Hosp Wash.
(Town, county, and state)
10. Usual occupation —
11. Industry or business —

FATHER
12. Name Douglas Carlton Stevens
13. Birthplace Rockville Md.

MOTHER
14. Maiden name Martha Virginia Downs
15. Birthplace Montgomery

16. Informant San Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11 1947 (month) (day) (year)
Cemetery or crematory Goshen Mem. Cem.
Location Riggs Road
18. Funeral director J. Arthur Walters
Address 7 Carroll St. Tak Park

19. Nov. 11 1947 (Date rec'd by registrar) J. W. Arnold Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1947 at 10:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1947 to Nov. 9 1947
and that I last saw him alive on Nov. 9, 1947

Immediate cause of death Prematurity.
Patent ductus Arteriosus
Amniocele

DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death) 157m

Major findings of operations Amniocele – unable to completely replace viscera – ABD wall lacking Date of op. 11-4-47
Autopsy results Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Emma Hughes M.D. M. D. or other
Address Takoma Park Md Date signed 11-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

10212

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery

City or town Intersection of Gaithersburg Rd & Laytonsville road (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg (If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #1 Stewartown. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Walter Henry Stewart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col.	Married

6.(b) Name of husband or wife Louise Stewart

6.(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) January 21 1914

8. AGE: Years 33 | Months 10 | Days 8 | If less than one day: hrs. min.

9. Birthplace Gaithersburg, Maryland (Town, county, and state)

10. Usual occupation Janitor.

11. Industry or business

FATHER 12. Name Richard Henry Stewart

13. Birthplace Gaithersburg, Md.

MOTHER 14. Maiden name Rachel Posey

15. Birthplace Gaithersburg, Md.

16. Informant Almeida Winn - Sister

Address Gaithersburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1947 (month) (day) (year)

Cemetery or crematory Brooke Grove

Location Laytonsville, Md.

18. Funeral director R. L. Snouffer

Address 246 N. Wash. St. Rockville

19. 12/2 19 47 Almeida G. Winn Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1947, at 11:10 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1947, 19, to 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death Fracture of 2nd cervical Vertebra and crushed Chest with inter-thoracic hemorrhage	Killed instantly
Due to auto accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 11-29-47

Where did injury occur? near Laytonsville (City or town) montg (County) md (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury auto accident Injured at work? no

23. SIGNATURE Frank J. Brockhurst M.D. M. D. or other

Address Gaithersburg, Md. Date signed 11/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

10213

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 1 P.M. 11-24-'47

Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd. Bethesda Md.

How long in hospital or institution? since 1 P.M. 11-24-'47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mc Lean Gardens

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Miss Mary Stout

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
F	W	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1928

8. AGE: Years 19 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Viola, Kansas (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

FATHER 12. Name Charles Stout

13. Birthplace Viola Kansas

MOTHER 14. Maiden name Bernice Miller

15. Birthplace Viola Kansas

16. Informant Mrs. Edwin B. Miller

Address 2913 1st Rd. N. Arlington Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/26/47 (month) (day) (year)

Cemetery or crematory

Location Viola - Kans.

18. Funeral director The S. H. Hines Co.

Address 2901-14th St. N.W. D.C.

19. 11/25 1947 (Date rec'd by registrar) Mr E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1947 at 6:01 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 24 1947 to November 25 1947

and that I last saw h.. alive on November 24 1947

	DURATION
Immediate cause of death (a) Uremia acute.	2 days.
Due to (b) Chronic Nephritis	15 years
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry M. Fletcher M.D. M. D. or other

Address 3848 Porter St N.W. Washington 16 Date signed 11-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

10214

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County MONTGOMERY
City or town BETHESDA
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 YR.
Hospital, institution, or street address where death occurred:
SUBURBAN HOSPITAL 8600 GEORGETOWN RD. BETHESDA, Md.
How long in hospital or institution? 1 HOUR

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1914 STRATTON ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war NO.

3. (a) FULL NAME MYRON STOUT

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of ~~husband~~ or wife MARION H. STOUT
6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) JANUARY 14, 1901

8. AGE:

Years	Months	Days	If less than one day
46	10	16	..... hrs. ..... min.

9. Birthplace WASHINGTON, D.C.
(Town, county, and state)

10. Usual occupation CLERK

11. Industry or business WASHINGTON LOAN & TRUST Co.

FATHER
12. Name MYRON H. STOUT
13. Birthplace NEW YORK

MOTHER
14. Maiden name CARINDA COUTE
15. Birthplace ILL.

16. Informant WIFE. MRS. MARION H STOUT
Address 1914 STRATTON Rd. Sil. SPRING, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 3 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland Md.

18. Funeral director Joseph Gawler's Sons
Address 1756 Penna Ave, N.W. Wash, D.C.

19. 12-2-47 19..... (Date rec'd by registrar) JKE Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 30 1947 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to 19..... and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Thos J. Bosshart M.D. M. D. or other
Address Yarmouth Maine Date signed 11-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 10215

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 10-31-47
Hospital, Institution, or street address where death occurred Suburban Hosp. 8600 Old Georgetown Rd. - Bethesda MD.
How long in hospital or institution? Since 10-31-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4629 - 49th St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME George E. Stratton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or ~~divorced~~
M	W	

6.(b) Name of husband or wife Maude P. Stratton - Dec
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 2, 1873

8. AGE: Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace Blackland Mass. (Town, county, and state)
10. Usual occupation Civil Engineer
11. Industry or business
FATHER 12. Name Eber E. Stratton
13. Birthplace Blackland Mass.
MOTHER 14. Maiden name Electa Trowbridge
15. Birthplace Blackland Mass
18. Informant Miss Constance Stratton
Address 4629 49 St N.W.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 11/8/47 (month) (day) (year)
Cemetery or crematory Arms Cem
Location Shelburne Mass
18. Funeral director S. H. Hines Co.
Address 2901-14 St. N.W. D.C.
19. 11-8 1947 W.E. Hobbs
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 19 47 at 3.05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20 19 47 to Nov. 8 19 47 and that I last saw h. l. alive on Nov. 7 19 47

Immediate cause of death	DURATION
Coronary occlusion	
Myocardial Infarct	
Due to Pulmonary Congestion	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P. P. Andrews M.D. M. D. or other
Address Washington D.C. Date signed 11-8-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160 C

10216

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and concisely.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27¾ hrs.

Hospital, institution, or street address where death occurred:
Washington San & Hosp.

How long in hospital or institution 39 hrs & 6 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington D C
(If outside city or town limits, write RURAL and give nearest town)

Street No. 90 Webster N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas Carl Latham

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	—

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 5, 1947

8. AGE: Years — Months — Days 1 If less than one day 15 hrs. 6 min.

9. Birthplace Takoma Park Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Christopher Columbus Latham

13. Birthplace Craig, North Carolina

MOTHER 14. Maiden name Esther Elizabeth Ford

15. Birthplace Washington D.C.

16. Informant Father

Address 90 Webster St N.E. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8-1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Prince Georges Co. Maryland

18. Funeral director S. H. Hines Co

Address 2901-14th St. N.W. Washington D.C.

19. Nov 7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1947 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5 1947 to November 6 1947 and that I last saw him alive on November 6 1947

Immediate cause of death: Patent Ductus Arteriosus — DURATION: lifetime

Due to: Patent Foramen Ovale — (39 hrs.)

Due to: Prematurity (5 weeks pre-mature)

Other conditions: Cesarian Section for pre-mature separation of placenta in mother

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results see above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Katharine A. Chapman M.D.
M. D. or other

Address 20 West Baltimore St. Kensington, Md. Date signed 11/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 10217

CERTIFICATE OF DEATH

Reg. Dist. No. 3 7 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Spencerville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Spencerville

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: FRANCES EMMA THOMAS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Widowed

6.(b) Name of husband or wife: George Thomas

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 23 1867

8. AGE: Years 80 | Months 4 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace: Spencerville, Montgomery, Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business —

FATHER 12. Name: Wm. Simpson

FATHER 13. Birthplace: Spencerville, Md.

MOTHER 14. Maiden name: Margaret Mary Simpson

MOTHER 15. Birthplace: unknown

16. Informant: Edith Thomas

Address: Spencerville

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 17 1947 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Spencerville, Md

18. Funeral director: R. L. Swanton

Address: Rockville, Md

19. NOV. 17 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1947, at 8.00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to November 1947 and that I last saw her alive on November 13 1947

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: Hypertensive Heart Disease with Decompensation	
Due to	
Other conditions: Senility - Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Richard A. Yates M. D. (M. D. or other)

Address: RFD #3 Rockville Md Date signed 11/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83 b

10218

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg Co,
City or town: Gaithersburg Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Wilson Troxell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Faber Troxell
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 10 1875

8. AGE: Years	Months	Days	If less than one day
1875 71	6	21	hrs. min.

9. Birthplace: Emmittsburg Md Principal
(Town, county, and state)
10. Usual occupation: Retired, Teacher
11. Industry or business: " "

FATHER
12. Name: James W Troxell
13. Birthplace: Md

MOTHER
14. Maiden name: Mary E Zachariah
15. Birthplace: Md

16. Informant: Mrs Minnie Troxell
Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/3/47 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Md,

18. Funeral director: ERNEST C GARTNER
Address: Gaithersburg Md,

19. Nov 2 1947 (Date rec'd by registrar) Alveda S Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1st 1947 at 3.15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 29 1947 to Nov 1 1947 and that I last saw him alive on Oct 31 1947

Immediate cause of death	DURATION
Cerebral embolism	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: A J Brochart M.D.
M. D. or other
Address: Gaithersburg Md. Date signed 11-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The data is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

10219

CERTIFICATE OF DEATH

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: Unknown

3.(a) FULL NAME: Mr. Seldon Vaughan

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 13, 1888.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
59	0	8		

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Landscape work
11. Industry or business

FATHER
12. Name: Andrew Vaughan
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Theresa George
15. Birthplace: West Virginia

16. Informant: self
Address: Records-Suburban Hospital

17. Removal-Transit (Burial, cremation, or removal. Which?) Date thereof: Nov. 23, 1947 (month) (day) (year)
Cemetery or crematory: Barnette Funeral Home
Location: Hinton, West Virginia

18. Funeral director: Wm. Reuben Swamptney
Address: Bethesda 14, Maryland

19. 11 24 1947 (Date rec'd by registrar) Wm E Jules Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov - 21, 1947 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 47, to 21 Nov 19 47
and that I last saw h alive on 19

Immediate cause of death	DURATION
Heart failure	
Due to: Hypertensive Heart disease	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John S Lawrence M.D. M. D. or other
Address: Suburban Hosp. Date signed: 23 Nov 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

77c

Reg. Dist. No. 10220-14

1. PLACE OF DEATH:

County: Montg

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

died enroute to Cedarcroft san.

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1324 Ingraham St N.W

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: George N. Walker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Margaret Walker

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Aug 17 1899

8. AGE:

Years	Months	Days	If less than one day
47	2	19	...hrs. ...min.

9. Birthplace: Wash. D.C. (Town, county, and state)

10. Usual occupation: Ex. Sec. Laundry; dry cleaning amus

11. Industry or business: Laundry

FATHER — 12. Name: Frank Walker

FATHER — 13. Birthplace: D.C.

MOTHER — 14. Maiden name: Ottilia J. Stommel

MOTHER — 15. Birthplace: Newark, N.J.

16. Informant: Margaret Walker

Address 1324 Ingraham St D.C.

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof Nov 7-47

Cemetery or crematory: Rock Creek cemetery

Location: Wash D.C.

18. Funeral director: THE S.H HINES

Address 2901-14-57 46

19. Nov. 7 19 47 (Date rec'd by registrar) Josephine M. Schaaff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6 19 47, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 2nd Med Exam case, 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral edema	12 hrs.
Due to	
Due to	
Other conditions: Acute alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Bosshart M.D. M. D. or other

Address: Gaithersburg Md. Date signed 11-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940 10221

CERTIFICATE OF DEATH

Reg. Dist. No. 5/14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3hrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2011 Landsdowne Way
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Clarence J. Warnick

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Nelle Lee Warnick
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 7, 1885

8. AGE: Years	Months	Days	If less than one day
62	6	1	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Oil Burner Business
11. Industry or business

FATHER
12. Name: Charles Warnick
13. Birthplace: Maryland

MOTHER
14. Maiden name: Katherine Otto
15. Birthplace: Maryland

16. Informant: Don Warnick
Address: Manhasset, N. Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12. 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Prince Georges Co. Md.

18. Funeral director: Wm Lee Sons Co
Address: 305 4th. St. N. E. Washington, D. C.

19. Nov. 10 19 47 Joseph M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 Nov 1947, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to 8 Nov 1947
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Thrombosis	1 hour
Due to: Coronary sclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William D. Abel M.D.
M. D. or other
Address: 9006 Colesville Rd, Silver Spring Date signed: 8 Nov 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10222

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Etchison
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, Institution, or street address where death occurred:
None
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Etchison
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ********** JOHN BAPTIST WATERS **********

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Ray Waters
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): December 27, 1880

8. AGE: Years	Months	Days	If less than one day
66	10	8	— hrs. — min.

9. Birthplace: Jersey City, N. J. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming

FATHER
12. Name: John Waters
13. Birthplace: Ireland

MOTHER
14. Maiden name: Elizabeth Smith
15. Birthplace: Ireland

16. Informant: Mrs. Mary Ray Waters
Address: Etchison, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 6/47 (month) (day) (year)
Cemetery or crematory: Grace Episcopal Church Cem.
Location: Woodside, Maryland

18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda, Maryland

19. 10/6 (Date rec'd by registrar) 19 47 Rhoda L. Locke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4, 1947, at 5:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1947 to November 4, 1947 and that I last saw him alive on November 4, 1947

Immediate cause of death: Coronary occlusion — DURATION: 3 days.
Due to: Arteriosclerosis.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D.
M. D. or other
Address: Damascus, Md. Date signed: 11/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11454

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Howard.

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. Star Route

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gerald Marvin Wessel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single-

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 26, 1947

8. AGE:

Years	Months	Days	If less than one day
		1	hrs. min.

9. Birthplace: Olney, Montgomery Co., Maryland.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER

12. Name: Roland Frederick Wessel

13. Birthplace: Fulton, Maryland.

MOTHER

14. Maiden name: Dorothy Elizabeth Latley

15. Birthplace: Laurel, Maryland

16. Informant: Hospital records.

Address: Mercy Co Hospital St. Paul

17. (Burial, cremation, or removal. Which?) Date thereof: Nov 29 -1947 (month) (day) (year)

Cemetery or crematory: Burial St. Paul Fulton Md

Location: Fulton Md

18. Funeral director: De Witt Bowersox

Address: Laurel Md

19. Dec 1 1947 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 19.47, at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26 19.47, to Nov. 27 19.47 and that I last saw h. r. m. alive on November 27 19.47

Immediate cause of death	DURATION
Asphyxia	12 hrs
Pneumonia	
Due to: Premature Birth; Vomited & aspirated	
Due to: Prematurity	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring Md Date signed 11/27/47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

161a

Reg. Diat. No. 102224 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 min.

Hospital, institution, or street address where death occurred: Washington Sanitarium & Hosp.

How long in hospital or institution? 34 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 915 Garland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Unnamed Baby Westberg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	white	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): November 28, 1947

8. AGE: Years ____ Months ____ Days ____ If less than one day: ____ hrs. 34 min.

9. Birthplace: Takoma Park Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Westberg, Vincent Brax

13. Birthplace: Waukegan Illinois

MOTHER

14. Maiden name: Perrin, Gladys Jane

15. Birthplace: Ethel, Missouri

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 29, 1947 (month) (day) (year)

Cemetery or crematory: Geo. Washington Mem. Cemetery

Location: Riggs Rd. Hyattsville, Md.

18. Funeral director: J. Leathen Walters.

Address: 254 Rhode Island Ave. N.W. Wash. D.C.

19. Nov. 29 1947 (Date rec'd by registrar) J. Milton Waldon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28, 1947, at 8 45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-28-1947, to 11-28-1947 and that I last saw her alive on 11-28-1947

Immediate cause of death: Atelectasis lungs in new born — DURATION

Due to: Cause unknown

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Emma Hughes M.D. M.D. or other

Address: Takoma Park, Md. Date signed: 11-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10224

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months 21 days
Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 8 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 403 Hilton Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: WW II

3.(a) FULL NAME: WHITELEY, Benjamin (nmi) Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: Mrs. Benjamin Whiteley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 20 May 1926

8. AGE: Years	Months	Days	If less than one day
21	6	1	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: U. S. Navy
11. Industry or business
FATHER 12. Name: Benjamin Whiteley Sr.
13. Birthplace: Maryland
MOTHER 14. Maiden name: Clarita Dalcour
15. Birthplace: Maryland
16. Informant: U. S. Naval Records
Address
17. burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 23, 1947 (month) (day) (year)
Cemetery or crematory: Laudon Park Cemetery
Location: Baltimore, Maryland
18. Funeral director: W. W. Chambers Co. E.S.J.
Address: 1400 Chapin St., NW, Washington, D.C.
19. 11-22 1947 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 November 1947 at 5:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1- 1947 to 11-21- 1947 and that I last saw him alive on 11-21- 1947

Immediate cause of death	DURATION
Rhabdomyosarcoma of the foot with wide spread metastasis	8 mos.
Due to	
Due to	
Other conditions: Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: Rhabdomyosarcoma foot — amputation foot. Date of op.: April 47
Autopsy results: Wide spread metastasis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

W. P. Horton
23. SIGNATURE: W. P. HORTON, LTJG MC USNR
M. D. or other
Address: USNH, Bethesda, Maryland Date signed: 11-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10225

117a

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 938 Shepard St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am. & WWI

3.(a) FULL NAME: WILLIAMS, John Benjamin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 5, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	22	hrs. min.

9. Birthplace: Penn. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER — 12. Name: WILLIAMS, Benoni dec.

13. Birthplace: Pa.

MOTHER — 14. Maiden name: SIMPSON, Mary Jane dec.

15. Birthplace: Pa.

16. Informant: daughter: Mrs. Lenora Howe

Address: 938 Shepard St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12-1-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS Per J.P.W.

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 11-28 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 19 47 at 4:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 November 19 47, to 27 November 19 47

and that I last saw him alive on 27 November 19 47

Immediate cause of death: Gastro-Intestinal hemorrhage. — DURATION: one day

Due to: perforated peptic ulcer — DURATION: 2 days

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. R. TRUE W. R. True, Lt. JG MC USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10226

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mons. 7 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 mons. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va. County: Arlington

City or town: Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 829 20th St., So.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: WILSON, Harry Macon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Myrtle Wilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 26, 1877

8. AGE: Years	Months	Days	If less than one day
69	11	11	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Retired - U.S. Naval Gun Factory - Washington, D.C.

11. Industry or business

FATHER

12. Name: Wilson, Erick dec.

13. Birthplace: Virginia

MOTHER

14. Maiden name: Baskett, Sueanna dec.

15. Birthplace: Virginia

16. Informant: wife: Mrs. Myrtle Wilson

Address: 829 20th St., So., Arlington, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Wheatley Funeral Home

Address: Alexandria, Va.

19. 11-7- 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 1947 at 2:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1947 to Nov. 7 1947 and that I last saw him alive on 7 Nov. 1947

Immediate cause of death	DURATION
Coronary Thrombosis	48 hrs
Due to: Generalized and Coronary arteriosclerosis	? years
Due to: Hypertensive Cardio-Vascular-renal disease	? years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. C. Messerschmidt LT (MC) USNR M. D. or other

Address: USNH - Bethesda, Md. Date signed: Nov 7, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10227

CERTIFICATE OF DEATH

Reg. Dist. No. 718

1. PLACE OF DEATH:
County Montgomery
City or town RURAL - Brookeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town RURAL - Brookeville.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Sarah McKhemery WILSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Wh	Widowed

8.(b) Name of husband or wife David F. Wilson
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 26, 1865

8. AGE: Years	Months	Days	If less than one day
82	4	4	..... hrs. ..... min.

9. Birthplace Charlestown W. Va. (Town, county, and state)
10. Usual occupation housewife
11. Industry or business —

FATHER
12. Name John Wesley Ashby
13. Birthplace Ireland

MOTHER
14. Maiden name Susan Ware
15. Birthplace Virginia

16. Informant David F. Wilson
Address Brookeville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 2, 1947 (month) (day) (year)
Cemetery or ~~crematory~~ Pleasant Hill
Location Barnstown (Kelly Farm)
18. Funeral director Ray W. Barker
Address Laytonsville Md.

19. 12/1/47 (Date rec'd by registrar) L. D. Dell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1947, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946, to Nov. 30 1947
and that I last saw her alive on Nov. 27 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	—
Due to Essential Hypertension	years
Due to Hypertensive Cardio-vascular-Renal Disease	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of .....
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury ..... Injured at work?

23. SIGNATURE Richard A. Yates M. D.
M. D. or other
Address RFD #3 Rockville Md. Date signed 11/30/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10228

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3919 R Street, Southeast

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: WINGO, Clyde Arlington

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Jenny Wingo

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 16 June 1895

8. AGE: Years	Months	Days	If less than one day
52	4	22	hrs. min.

9. Birthplace: Virginia (town, county, and state)

10. Usual occupation: Special Agent

11. Industry or business: Southern Railway

FATHER

12. Name: Floyd J. Wingo

13. Birthplace: Virginia, deceased

MOTHER

14. Maiden name: Cora Green

15. Birthplace: Virginia, deceased

16. Informant: Wife: Mrs. Jenny Wingo

Address: 3919 R St., SE, Washington, D. C.

17. burial (Burial, cremation, or removal: Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Oakwood Cemetery

Location: Richmond, Virginia

18. Funeral director: S. H. Hines Funeral Co. W.H.

Address: 2901 14th St. NW, Washington, D. C.

19. 11-8 19 47 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 November 19 47 at 8:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-3- 19 47 to 11-7- 19 47 and that I last saw h... im alive on 11-7- 19 47

	DURATION
Immediate cause of death: Sudden coronary occlusion	4-5 min
Due to: Coronary Heart Disease Arteriosclerotic	4-5 yrs
Due to:	
Other conditions: Hypertension — Arterial; Old Cerebral Thrombosis	10 yrs+ 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of OB:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Hugh Stevens Jr. M.D.

M. D. or other

Address: USNH, Bethesda, Md. Date signed: 11-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

WS AUG 9-425-15M